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United States Agency for International Development
World Vision

THIRD ANNUAL REVIEW REPORT

Ballia Rural Integrated Child Survival Project
Uttar Pradesh, India
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LIST OF ACRONYMS

ADP	Area Development Program
ANM	Auxiliary Nurse Midwife
APRO	Asia Pacific Regional Office
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCG	Bacillus Calmette Guerin
CBDDS	Community based Disease and Death Surveillance
CDO	Community Development Organizer
CMO	Chief Medical Officer
CSP	Child Survival Project
DPT	Diphtheria, Pertussis, Tetanus
DTI	District Training Institute
EOP	End Of Project
EPI	Expanded Program on Immunization
GOI	Government of India
GSS	Gramin Swasthya Sevika (Hindi for Community Health Worker)
KPC	Knowledge, Practice, Coverage
LCO	Lady Community Organizer
LQAS	Lot Quality Assurance Survey
ICDS	Integrated Child Development Scheme
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTE	Mid Term Evaluation
NFHS	National and Family Health Survey
NGO	Non Governmental Organization
NZ	North Zone
OPV	Oral Polio Vaccine
POA	Plan of Action
PHC	Primary Health Center
PVO	Private Voluntary Organization
TAR	Third Annual Review
TOT	Training of Trainers
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision

1. Executive Summary

World Vision is implementing a four year Child Survival Project in the Ballia District partnering with the Ministry of health, Government of India and the Ballia District Chief Medical Officer. The project started on October 1998, and will continue till September 2002.

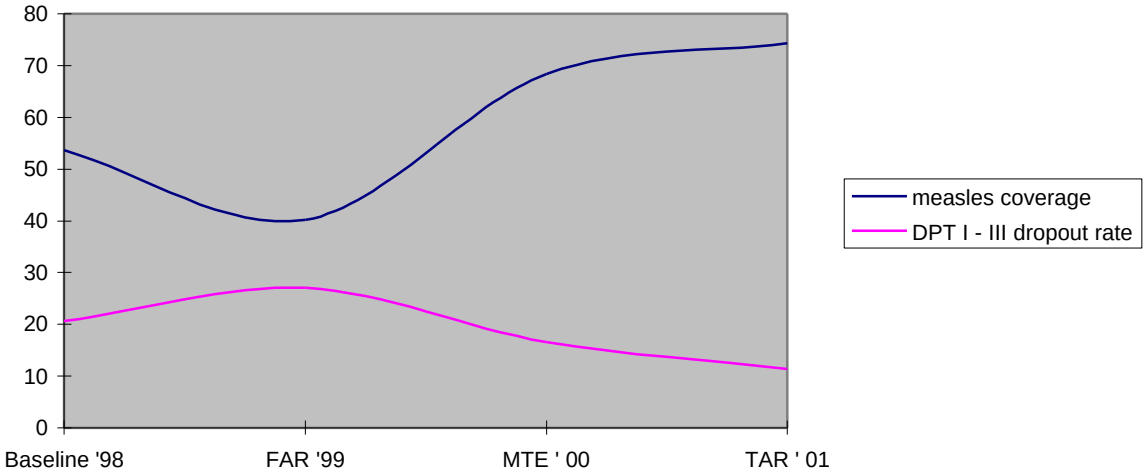
As required by the cooperative agreement between World Vision and USAID, a Third Annual Report has to be submitted to USAID by October 30, 2001(delayed until January 31, 2002). For this purpose the Third Annual Review was conducted from October 02, 2001 to October 06, 2001. Due to unavoidable circumstances, external members of the review team were not able to attend the review. A review team comprising staff of World Vision India Zonal and National Office Monitoring and Evaluation Department, Operations Department, MOH staff, Head of Partner NGOs, and BRICS project staff carried out the review, which was participatory in nature. The process followed here was similar to that of the MTE.

The BRICS project has made a steady progress towards the achievement of the desired benchmarks against the sub results indicators, despite the enormity of the task in terms of expansion of the focus to the entire district and investment of energy towards it. The project developed an integrated BCC package for the use of the GSS. These BCC materials have been well appreciated by the local USAID mission, and have plans to use them for their SIFPSA project. In a concerted effort along with all the stakeholders, KPC surveys were done for all the 16 blocks of the district that comprises the Project's indirect impact area. This massive exercise in terms of human resource and logistics has resulted in a wealth of information block wise for Ballia.

BRICS has built the capacity of several players in the technical area, some of them worth mentioning here are 135 RMPS who are trained in providing Birth Spacing counseling, and are also depot holders for the contraceptives. 330 TBAS are trained District wide in safe delivery practices, referral and essential care of the newborn. The capacity of the 6 local NGOs have also been built in various areas of child survival. All these NGOs along with the BRICS project have established a strong network, which is now recognized by the District Authorities including the Chief Medical Officer. These are some of the efforts BRICS has made in sustaining the program.

Some of the significant findings of the KPC are: % of children between 12 –23 months who are fully immunized is raised from baseline figure of 20.9% to 74.3%. Immunization trend (below) shows that there is a significant increase in the measles coverage and significant reduction in the DPT drop out rate. TT coverage has increased from 5.6% to 85.9%. Although the children 0-4 months who are exclusively breastfed are 92%, there is a significant drop in the exclusive breastfeeding trend after 4 months. Complementary feeding practices have increased from a baseline figure of 25.8% to 79.9%. 23.4% of families who desire no more children or are not sure were reported using modern contraceptive methods. It was clearly evident that the shift of

roles of field worker and the expansion activities of the project in other blocks did not affect the progress.



Some of the challenges for the project ahead are: improving Sterilization techniques and cold chain, intensifying the work in two model blocks namely Bansdih with Panchayat and Chilkahar with ICDS, ensuring Quality and coverage in the maintenance of the village based EPI and Pregnancy registers, Communicating the uniform Behavior Change messages in light of the new protocol, Coordination between the ANMs and the GSS in across the blocks, Developing the strategy and mechanism to provide support to the supervisors in the various blocks to ensure the quality, Using the BCC materials and transfer the messages to the mothers, Support-a- vision to the NGOs and the turn over of the staff

Major recommendations to the project are as below:

- Ensure proper sterilization technique and the cold chain at the ANM level
- Children tracked by the BRICS since its inception should now be enrolled in the Early Childhood Care and Development.
- Intensify the work in the two pilot testing blocks
- Conduct CQI workshop for the NGO partners and the MOH staff
- Develop a strategy for mainstreaming in 4 UP ADPs.
- Conduct OD workshop for the partner NGOs.
- Re-look into the operational strategy of the partnership, so that it is in line with the strength of the NGOs, giving scope for innovation and yet fulfill the expectation of the BRICS.
- Address staff stress related issues at all levels.
- Consult with the finance department in the Zone/ National
- Office regarding FCRA policies and the transfer of funds to the
- partners as reimbursement grant.
- Review into the work distribution of the staff at all levels.

- Fill in all the vacancies
- Request USAID for no cost extension

2. Introduction

World Vision is implementing a four year Child Survival Project in the Ballia District partnering with the Ministry of health, Government of India and the Ballia District Chief Medical Officer. The project started on October 1998, and will continue till September 2002.

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Ballia District located in eastern UP on the Bihar border, has been identified as having some of the highest rates of under five morbidity, disability and mortality in India. Available demographic data, the intermediate result targets in the DIP are summarized below.

Baseline Vital Statistics		
Indicator	**Baseline**	**Method**
Infant Mortality	99.9/1000 live births	NFHS
Under Five Mortality	141 per 1000 live births	NFHS
Neonatal Mortality	60 per 1000 live births	
Moderate and Severe Wasting	43% 0 –23 months	Sample Survey
Fertility Rate	4.82 per women at 45	NFHS
Maternal Mortality	570 per 1000 live births	NFHS
Night Blindness	2.97% of 9-35 months	Survey

The USAID/BHR/PVC Guidelines for the Third Annual Report (CS-XIII issued May 2000) and the Third Annual Review Scope of Work prepared by the BRICS project were used as the general guidelines. The review team used the following framework for the review.

Frame work for the Third Annual Review	
Quality of the Program	EPI Checklist Community based registers checklist
Coverage	KPC findings Example: Immunization Coverage
Behavior Change	Trend in the breast feeding
Knowledge	KPC findings on mothers knowledge on danger signs FGD with Dais: when to refer
Inputs	Pipe line analysis, Man days used for Capacity Building

3. Expectations of the Third Annual Review

- Show us the way to go in year four - Beulah
- How the MOH is functioning and service delivery - B Sharma
- Staff security - Deepak
- Is there another way to do a Review - Khalko
- Comparative study of the 3 models and identify the sustainable one - KK Singh
- How to change the attitude of MOH and ICDS staff - Anant
- What will be the new strategy after Sep 2002 - Akbar
- How to motivate the Panchayat to make a body to mobilize the community - Sanjay Masih
- Critical review of work done so far and feedback - Tej Bahadur
- What is withdrawal strategy - Mazhar
- To assess sustainability of the strategies - Bradley
- What will happen once the CSP closes - Sasi
- How to go in depth and in what certain areas - KA Jayakumar
- How to evaluate behavior change - Manju
- How to sort out challenges before us - Shrivastava
- How to strengthen organization - Ghanshyam
- How to go in depth - Jeetender
- To assess long term impact on people - Father Gyan Prakash
- How to build field staff - S Singh
- Staff security - Nischal
- How to improve quality in partner NGO area - Anthony
- How to obtain an extension - Uttam & Stephen
- How to integrate MED with BRICS - Kumar
- Technical training for ANMs in all the district / remuneration for TBAs - Ruby
- Staff security - Sunita
- How to move forward - Anita Joshua
- Strengths and weaknesses of the CSP - Lini
- Deeper linkages - Shailender

- Integration with sponsorship - Amit
- To learn how to evaluate esp. partnerships - Sushma
- Has there been a paradigm shift in thinking process among the NGOs - Subodh

4. Methodology for the Third Annual Review

The third annual review of ADP Ballia was scheduled from October 02, 2001 to October 06, 2001 with the following objectives:

- To review the accomplishments and the constraints of the project from the start to the end of the third year comparing the actual accomplishment with the set goals and objectives, results, and/or outputs established in the Detailed Implementation Plan for the period.
- To identify factors which have contributed to the achievement of the progress and factors that have impeded progress and make recommendations.
- To identify any substantial changes required from the approved agreement and DIP which require a modification to the cooperative agreement and recommend if any are found.
- To review the MTE evaluation recommendations and identify how the project is addressing the MTE evaluation and document any other actions taken as a result of the evaluation.

Review Team

The review was facilitated by a review team comprising of Sushma Cornelius, Operations Manager, World Vision-NZ, Subodh Kumar, Monitoring and Evaluation officer, World Vision-NZ, Manju Mathews, Program Officer, Bradley Thomson, Monitoring & Evaluation Associate, World Vision India, Sasmita Swain Monitoring & Evaluation Associate, World Vision India , Dr Ivan, Area Coordinator, World Vision Myanmar, S Jeyakumar, Manager ADP Aparajita, World Vision North Zone.

Stakeholder participants:

The Chief Medical Officer for Ballia District Dr O.P. Singh participated in the review. He formally addressed the review team and the Brics staff on the first day. He also participated in the presentations made by the BRICS staff. Dr Ashok Kumar, Medical Officer, Beruarberi block, Dr D.P. Singh, Medical Officer, Bansdih Block and Dr Gupta Medical Officer Chilkahar block participated in the review. They did their presentations on the first day, and acknowledge the BRICS contribution in improving the quality of the services rendered by their PHCs. Dr Mazahar A Rashidi (Prstinidhi Sansthan), Father Gyan (Purvanchal Gramin Chetna Samiti), Tej Bahadur Singh (Subhash Memorial Sansthan), Dr Sushil Kishore Srivastava (Naval Shikshan Sansthan), (Solanki Gramodhyog Sansthan), Jeetendera Chauhan (Gramothan Vikas Ashram), participated in the entire review. They made presentations of their work, and the future plan of the partnership. Their field was visited on the second day and the review team also met them together in the partners review meeting. Other participants included Dais, RMPs, GSS,

Pradhans, ANMs and mothers, who were visited during the course of their duties, and for some, the meetings were convened to gather information so as to enable the review team to analyze it in order to reach its objectives of the TAR.

Sources of Data

The data collection for the review included both the quantitative methodology and the qualitative methodology from secondary and the primary sources. A KPC survey was conducted and the data was compared with the specific benchmark set for the third year of the project. The data was triangulated by the FGDs done with the stakeholders in the process of review, to validate the KPC findings. It is worth mentioning here that the capacity of the BRICS staff is sufficiently built in order to administer the KPC and do the analysis independently. It is also worth mentioning here the innovation BRICS staff brought about in the present KPC. Parallel sampling was used in order to increase the size of sub samples, and reduce recall bias, as per the time taken for the each interview. As earlier raised by the Government counterpart, the history of the immunization was also considered in the KPC. History based results are also shown in the 'results' section of the KPC report. For want of space and time history based results were not shown in graphs. The other record reviewed during the process are EPI Registers, Pregnancy registers, and the Family planning registers in the entire 17 blocks of the Ballia District. Also reviewed are the technical support materials of the project, BCC materials produced by the project, and the record keeping of the project.

The major source of the information came from oral reporting of the various stakeholders. Our conversations with the health service providers, TBAs, ICDS workers, NGO partners, community members, MOH staff gave us insights into the projects activities and the partners activities, their acceptability, and crucially, the processes, which have contributed to the success or impediment of the specific interventions.

Methods of Data Collection

Following methods were used for the data collection:

- The KPC was conducted according the WHO standard 30-cluster methodology. This year the Parallel sampling was used in order to increase the size of sub samples, and reduce recall bias, and the time taken for each interview. As earlier raised by the Government counterpart, the history of the immunization was also considered in the KPC.
- Focus group discussion with Dais, RMPs, GSS to assess the increase in knowledge, practice, behavior changes, quality of services and to triangulate the KPC findings.
- Structured interviews with the BRICS team to understand the team dynamics, their vision for the communities, constraints and challenges.
- Using the structured form developed by the MTE team monitored behaviour of ANMs.

- They did observation and the SWOT analysis to assess partners' capacity, increased capability, acceptance in the community and ownership of the CSP activities.
- Though the day was long it concluded with the debriefing from all the teams and the individual lessons learnt each day.

Feedback and recommendations

As per the purpose stated in the terms of reference for the third annual review, recommendations were made in two major areas: for the BRICS and the Partners.

Debriefing was conducted with the BRICS staff and the Partner NGOS on October 06, 2001 to create ownership, empowerment and excitement.

The draft report was handed over to BRICS team prior to the departure of the review team.

5. Project Background

Area Development Programs (ADP) are World Vision's core programming unit worldwide, having different sectoral activities covering a single geographic unit, (which, in the case of India, is the block) and planning to subsequently radiate more such units.

Ballia ADP began in November 1996 and its areas of emphasis include health, income generation, infrastructure development, early childhood care and development and local leadership development. The plan of activities is being jointly developed with the community and has objectively verifiable results and a plan for sustainability. Most of the funding for ADP activities is drawn from child sponsorship and at present there are 1288 sponsored children in ADP Ballia.

Ballia Area Development Program is located in the remote and under served Ballia district in the eastern part of Uttar Pradesh state, 20 km from the border with Bihar state. Ballia is 4 hours' drive from Varanasi, the nearest airport.

CHILD SURVIVAL PROJECT

The Ballia CSP is nestled within the 15 - year Ballia Area Development Program (ADP). The Ballia CSP, funded through a cooperative agreement of World Vision with USAID, was initiated in October 1998, in collaboration with the GOI and the Ballia CMO.

The direct impact area of the CSP is Beruarbari, the largest block of Ballia district, with a population of 150,121 comprising of 82 villages. The CSP has been working in this block in a phased manner with, all the 82 villages being covered in the third year. Three KPC surveys have been done in this direct impact area to assess the progress against the baseline. The project in the third year was able to scale up in the remaining 16 blocks covering 2.5 million population

MODUS OPERANDI OF WORK

The Ballia CSP does not provide direct services, but rather operates in the following ways –

- ***Mobilizing*** - a cadre of village based health workers called Gramin Swasthya Sevikas (GSS) who are trained on the technical aspects of the intervention areas as well as in BCC and counseling skills. This is a conscious effort towards sustaining the benefits.
- ***Capacity Building*** - of the GSS and local stakeholders viz, MOH staff, community leaders and partner NGOs;
- ***Linking*** - beneficiaries with care providers, through the GSS and community leaders;
- ***Planning –*** with the MOH and the community for increasing coverage;
- ***Advocacy and support –*** for improving quality and meeting the demand by continuous supply.

Based on the recommendations of the MTE, the motivated team of the BRICS project was able to make a dent in the following areas:

Smooth transition of CDO's roles to GSS. Presently CDOs are playing the role of support a visor rather than supervisors of GSS. This transition had build the capacities of both in many areas, including the technical areas.

BRICS was able to scale up its activities to the entire district. The project has its operation in all the 17 blocks with the partnership of NGOs. 582 GSS are working at the grass root level to bring in a behavioral change in the lives of mothers.

Concomitant growth in staff capacity in conceptual and technical aspects. The project organized 5 different TOT where the staffs were trained as lead trainers. Evidences were visible during the team's discussion with GSS and community that staff trained, as lead trainers were able to pass on their knowledge to the next level.

Baseline KPC was conducted for the entire Ballia District and the data are now available for the District. This was utilized by the project to plan the interventions.

Systems for tracking all pregnancies and infants in the district were established.

Integrated BCC package was developed to promote awareness and behavioral change amongst the target audience. It has been developed in the local dialect to effectively pass the messages.

Maintaining the quality of the cold chain in the entire district was one of the major challenge for project and for Chief Medical) Officer. The project brought all Medical Officers and Immunization Officers on one platform to discuss the issue of improving cold chain status in all blocks of Ballia district. Fourteen recommendations were finalized and the project started implementing two of the main issues that are; installation

of stabilizers in all PHCs in order to decrease the fluctuation of power supply; secondly project has initiated to repair the existing generators in all PHC and power connection for ILR for continuous power supply.

Partner NGOs organization capacity and knowledge on technical aspects has tremendously improved. Due to this the organizational image, presence in the grass root level, working climate, ability of accessing funds from various donors and management skills have improved.

Project also addresses the indirect causes of poor health status such as poor infrastructure, sanitation and poverty. Project constructed 3 drains to reduce water borne diseases like diarrhea and malaria. 6 roads were constructed for easy access to referral point during obstetric emergencies, local market, Government departments and schooling during monsoons.

To address the issue of poverty the project has initiated 156 Self-help groups, and also ventured to provide loans to the needy families, so that their economic conditions improved and they are able to meet their health needs.

6. Models of Replication

MTE team in its recommendation has advised the project to test at least two different models for mainstreaming. The project identified three models for expansion, namely the Panchayat Model, the ICDS model and the NGOs model. Following table shows the models in greater detail:

Models of Replication	Blocks covered	Implementing partner
Panchayat Model	Bansdih	ADP Ballia
ICDS Model	Chilkahar	ADP Ballia
NGOS Model	Rasra, NavaNagar, Siyar, Nagra, Maniar, Pandah, Hanumanganj, Sohanv, Reoti, Morlichapra, Dubar, Garwar, Belhari, Bairiya	Partner NGOs.

Panchayat Model

Panchayat is an elected body by the community for a period of five years. Each Panchayat has 6 committees, out of which one is called as Health Committee. The mandate of the health committee is to look into the health issues of their panchayat area and take the necessary action.

The Panchayat model has greater chances of sustainability. Unlike the GSS in the Beruarbari block, the Panchayat appoints the GSS in this model, and the project does not pay any remuneration to these selected GSS. The role of the Project is train these GSS in technical interventions, BCC and link them with the ANM and the PHC. They

then work as the team. The GSS works as the catalyst, and mobilizes the community, provide them education on health issues and also keep panchayat updated, and mobilized to address issues related to maternal and child health.

During the review, the review team looked into this model. It was only four months, since the project launched this model. All the panchayat were able to form their health committees, and select the GSS. The project was yet to train these health committee member on roles and responsibility of the members. The project has developed a module called "***Disha***" which will provide direction to the panchayat in implementing the maternal and child health programs.

Review team arrived at a consensus that it is too early to comment on the efficacy of this model and its replicability. This has left for the end of the project evaluation team to comment on this.

ICDS Model

Integrated Child Development Services is World Bank/ USAID funded program of Government of India for Early Child Hood Care. The program is being implemented in few blocks for almost 10 years, now and it is subsequently being scaled up in the remaining blocks of Ballia District.

A Program Officer, who reports to CDO, an IAS Officer, is heading the Program. A worker selected from a village called as an ICDS worker implements it at the grass root level. There is one ICDS worker on a population of 1000. The target beneficiaries in the ICDS program are very limited. On an average an ICDS worker tracks 8 pregnant women and follows them up till they deliver and the child is fully immunized.

The challenge for the Brics project was to work with the available infrastructure of ICDS, instead of selecting new GSS in Chilkahar block. They needed a paradigm shift to cover more beneficiaries. " Earlier we felt that this will increase our work pressure, but with the capacity that was built in the process motivated us go house to house and cover more population," commented an ICDS worker.

The project was able to train all 125 ICDS worker in Chilkahar block and motivated them to work in close association with the ANM to improve the coverage in this block.

Although the continuity of the ICDS program itself is questionable, the coverage one receives with the infrastructure available is quite good. The review team in consensus decided that it is too early to comment on the replicability and efficacy and left it for the end of the project evaluation to comment on this.

NGOS Model

In the fourteen blocks of Ballia District Project is testing NGOs model. The project has established a NGOS network, with ADP Ballia providing space for the secretariat. The process was started with the partner NGOS coming together and developing common vision for the partnership. The NGOS together named this network as **" Partnership for sustainable child survival"**

Annexure IX-X shows the detailed mapping of the partnership. The project has a written agreement with the partner NGOS to assist the project in mainstreaming within the District. BRICS role is to build the capacity of the partner both in technical and organizational development skills. NGO partners have identified the GSS (there are 25-30 GSS in each of the 14 blocks) who are provided nominal support by the BRICS project. It is the responsibility of the partner to network with the PHC and improve the quality of the program. BRICS project provide them technical backstopping.

7. Capacity Building:

As mentioned in the several places in the report, BRICS project is a capacity building project and not a service delivery project. The objectives for the third year of the project were:

- Capacity building of available human resources.
- Capacity Building of CMO, PHC, ADP, NGO staff & Other ADP staff for mainstreaming.
- Capacity building of Panchayat, RMP's, TBAs, GSS.

Training of Trainers:

One of the major achievements of the BRICS project in third year was the scaling up in all the 17 blocks of Ballia District. This required the testing up of various models as discussed in the section 6. Massive task force of 581 GSS was identified, and they required their capacity to be build up. This was only possible if there are certain lead trainers on various issues available with in the project.

Following table shows TOT's conducted and the man-days utilized:

a)	GSS TOT for GSS trainers	10 Persons
b)	TOT for TBA trainers (Swatch)	14 Daiy
c)	Survey Coordinators	30 Persons
d)	TOT for Family Planning	14 Persons
e)	TOT in Panchayat RCH	07 Persons

Table showing the TOT conducted and the man-days used:

No. of Lead Trainers	Total Days	No. of Batches	Man-days Spent	Material Used
GSS TOT **a.** 10 (BRICS, NGO, Other ADP staff).	9	1	10p*1b*9d*= 90 MD	Manual, Audio Visual Aids etc.
DAI TOT **b**. 10 (ANM, BRICS, 2 other ADP staff	6	1	10p*1b*6d = 60 MD	Facilitated by SWACH Foundation (WHO trained persons)
Survey Coordinators TOT **c.** 32 (BRICS, MOIC, NGO, 14 other WV Projects.	4	1	1b*4d*32p = 128 MD	Manual, Stationary, Practical session on EPI info, Questionnaire, etc. Facilitated by Mr. Subodh Kumar, Ex Team Leader
Family Planning TOT **d**. 14 (BRICS, ICDS, Partner NGO staff	6	1	21p*1b*6d =126 MD	SIFSA trained master trainers
TOT for Pradhans RCH **e.** 6 (ADP, DTI, CMO, NGO staff)	5	1	6p*1b*5d = 30 MD	Master Trainers from CEDPA

Capacity building of the Gramin Swasthya Sevikas

The primary responsibility of communicating the BCC messages and mobilizing the community to avail the health services rests on the Gramin Swasthya Savikas. They meet regularly with community to impart BCC messages and to gather information to maintain community based Pregnancy and EPI registers and Family planning registers. GSS TOT was conducted for 9 days in which NGO staff, BRICS staff, Other ADP staffs were trained on the technical interventions of the BRICS project. ***The project has prepared a manual so that the trainers in the future follow up trainings can use it.***

Manual covers Community mobilization, Child health that includes IMCI, Immunization, Malnutrition and Vitamin A, and Reproductive Health. The mammoth task of training 581 GSS in the entire District was completed in a total of 35 batches of 7 days each in all the 17 Blocks of Ballia district. The lead trainers accomplished this task.

No. of GSS Trained	Total Batches	Total No. of Man-days.	Material Used
581	35 Batch of 7 days	581p*35b*7d* = 14,23,345 MD	Module, Stationary, Audio, Video etc.

Capacity building of Trained Birth Attendant

BRICS under its sub result, increased coverage of Reproductive Health has a mandate to reduce child and maternal mortality. For this its is essential to train the TBAS who conduct the maximum deliveries in the community. The project contacted SWACH Foundation at Chandigarh, to conduct TOT for the lead trainers who then in return will conduct trainings for the TBAS. Swatch has WHO trained facilitators. 10 lead trainers that include staff from BRICS, PHC and other ADP staffs were trained.

Topics covered in TBAs trainings are Safe delivery practices' including 5 cleans, Referral, and Essential newborn care. Following table shows the performance of the project:

No of TBA Trained	Blocks	Total Batches	Total Man-days	Material Used
330	14	30	330p*30b*5d = 49500 MD	TBA kit, Handbook, Flash Card, New Born Card etc.

Capacity building on conducting surveys for Monitoring and Evaluation

The expansion in the remaining 16 blocks of the Ballia District required conducting a baseline assessment of the BRICS indicators. It was not possible for the Project to conduct baselines on its own. A TOT was conducted to build the capacity of the partners, BRICS staff and the MOH staff on how to conduct the KPC survey. ***A manual on how to conduct sample surveys was also produced.***

The lead trainers in return trained 720 GSS and ANMS on conducting KPC surveys. The topics covered were interview techniques, randomization, selecting first household etc. Table below shows the man-days used:

No. of persons Trained	No. of Batches	Total Man-days	Material Used
720 persons	16	45p*16b*4d = 2880 MD	Manual, Field test, Flip Charts Stationary etc.

Capacity building of RMP (Family Planning).

Community based private practitioners (called RMP's) are key players in order to reach eligible couples with messages on birth spacing and provide them with the required supply.

TOT for family planning was conducted for NGO, ICDS and ADP staff. Issues such as Principles of FP/BS, FP Methods and Counseling were covered in this training. Thereafter the lead trainers provided training to RMPS.

No. of RMP Trained	Total Batches	Total Man-days
137	9 Batches of 4 Days	135p*9b*4d = 4860 MD

Capacity building of Panchayat.

Building the capacity of the Panchayat is the BRICS conscious efforts in sustaining the activities of the project. Panchayats are the most sustainable organization at the community level. Staffs from BRICS projects, District Training Institute, CMO office and other ADP's were trained as lead trainers in Panchayats Module on Reproductive Child Health. Technical Assistance was provided by CEDPA, and with their assistance a module called ' DISHA' was developed for further replication.

No. of person Trained	No. of Batches	Total Man-days	Material Used
213	7	213p*7b*2d = 2982 MD	Manual, Stationary etc.

Materials Produced:

The review team commends BRICS efforts in producing the following materials. These materials are very practical and could be used for further replication and mainstreaming of the BRICS activities in the other Districts where World Vision is working. USAID local mission has also appreciated the project's efforts in producing these materials, and has express their desire to further utilize these materials under USAID funded SIFPSA project, instead of re- inventing the wheel.

- Handbook for GSS trainers on Social Mobilization and RCH technical issues.
- Manual for survey coordinators for Monitoring and Evaluation.
- TBA flash cards.
- Newborn records.
- *Disha* Panchayati Raj RCH trainer's handbook.
- Integrated BCC Materials to be used by the grass root workers

8. Sustainability

Because of the very nature of the Third Annual Review, it was mandatory for the review team to look at the projects efforts towards sustainability, in keeping with the overall sustainability goal as outlined in the DIP.

Dr. Stan Foster, the Team Leader for the MTE outlined three perspectives of sustainability for the CSP in Ballia district. Sustainability was reviewed in light of the understanding of the three perspectives:

From World Vision's perspective:

i. Skills transfer will have led partner institutions to acquire the resources and capacity to manage and deliver CS/RH services after the World Vision phases out

ii. Communities, families and individuals will have been empowered to institutionalize the adoption of essential health care taking and health care seeking behaviors;

The review team found that the project is progressing towards achieving this.

- The project has successfully established links with the government, which was evidenced in the participation of the MOH officials in the review process. The quality improvement of the cold chain is almost being institutionalized.
- The section on the capacity building very clearly picturizes the efforts BRICS has put in order to build the capacity of various partners. This has certainly improved the skills to a great extent. The partner NGOS, BRICS staff can independently conduct KPC survey and train TBAS, and volunteers on the technical knowledge of CS/RH
- The greater demand for CS/RCH services, as found by the review team shows that the community has become aware of the need for such services. As shown by the graph in the breastfeeding section, it is evident that initiation of early breastfeeding is now becoming the community norm.

From Partners perspective:

i. They have the institutional, human, technical, material and financial resources to fund, lead and manage CS/RH services.

- The review team found that lot of efforts has been put in this area by the BRICS project. Several partners are now the lead trainers for Pradhans RCH, TBAS training, GSS technical training etc. The first phase OD was also conducted for these NGO partners to build the organizational capacity. NGO partners were assisted in developing the proposal and they were also trained in proposal writing. Two proposals by the NGOs in the area of Family Planning through empowering the Panchayats have been submitted to the donor agencies for funding. They have also been short-listed. This reveals that the project is progressing towards sustainability by the partner's perspective.

- However in the area of transfer of responsibility to the indigenous players there appears to be a gap.

From the beneficiary perspective:

i. They are empowered to make decisions about their own health and take ownership of plans to improve and monitor their own health.

- A lot of instances were reported where it was found that the beneficiaries are moving in the right direction towards decision- making on their own health issues.

Progress on the six sustainability strategies:

- Project needs to very clearly define its strategy of transferring the GSS to either Panchayats, or community organizations, or get them affiliated to the ICDS program.

- The project has almost achieved the goal of building the technical and managerial skills of the PHC staff and the staff of the CMO office. The discussions with the Medical Officers were evident that that their capacity is build and they are now in the process of being equipped to provide the quality services.

- In the area of mobilizing and strengthening entrepreneurship of key private sector actors in providing alternative CS services, the review team found that project has to deliberately make efforts in this direction.

- There is a need to reiterate the working with community groups to enhance their own financial capacity to ensure the CS/RH interventions are sustained. Though there were evidences of strengthening community structures to build capacity in CS/RH activities in the last evaluation, the review team did not find it this year. It may be due to the change in Leadership, and the understanding of the involvement of community organization in the CS/RH activities. The Leadership at present has a clear understanding of the involvement of community structures, it is recommended that it may be documented and get translated at all level.

- Project still has to work towards promoting self –financing of CS services through certain cost recovery mechanisms, resource generation methods and institute mechanisms to improve project cost effectiveness.

- A network has been established of the partner NGO's to take up advocacy and policy formation on CS issues. The ownership of the partnership and its programs is clearly evident. The partnership has gained recognition in the community and among local GONGOS.

9. Main Accomplishments

In the sections above it was evident that BRICS was able to show significant progress in the development component. Quantitative and qualitative analyses also indicates a significant progress towards achieving objectives under the technical interventions. This is commendable understanding the fact that program effort and focus shifted towards expansion into the indirect impact area.

Prevention of Malnutrition & Vitamin A deficiency

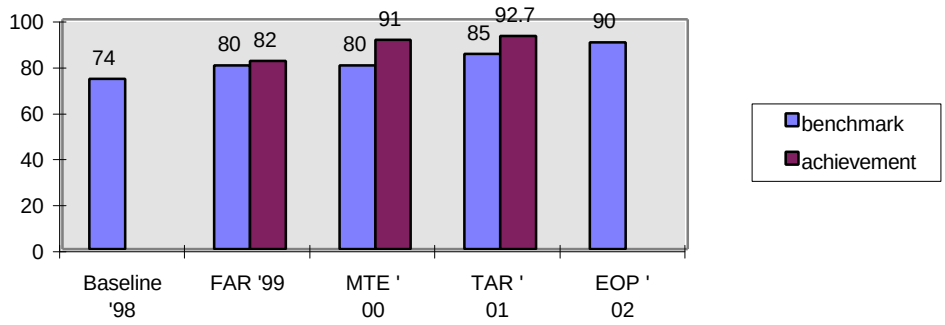
Malnutrition contributes to about half the deaths of the children under five in developing countries, and even in its milder forms malnutrition increases the risk of death. Leading authorities in public health nutrition have reviewed epidemiologic and programmatic data to identify most important nutrition objectives and effectiveness of programs to change these objectives. The essential package of nutrition interventions aims to achieve the following nutrition objectives:

- Exclusive breastfeeding of infants for about 6 months.
- Appropriate complementary feeding from about six months of age, and continued breastfeeding until 24 months.
- Appropriate nutritional management of all sick and malnourished children according to IMCI guidelines.
- Adequate intake of Vitamin A rich foods or vitamin A supplements by women, infants and children.

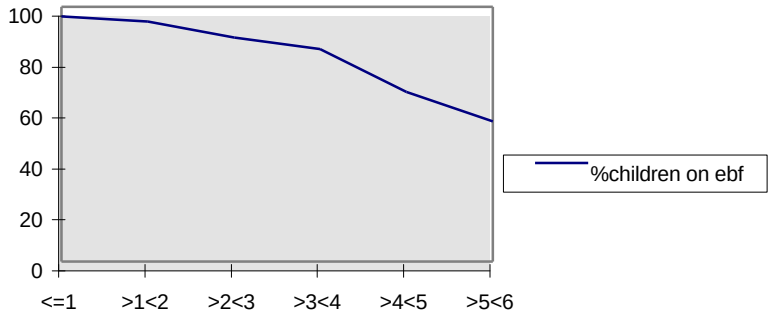
In order to achieve these objectives BRICS focused on locally relevant actions at community level and through BCC activities. BCC materials were developed using qualitative data on local practices, beliefs and terms for breastfeeding. Ethnographic study, if conducted, could have contributed to more effectiveness of the materials.

However, the KPC conducted showed the effectiveness of Exclusive Breast feeding up to 4 months of age has risen from 74% in 1998 in the direct impact area to 92.7% in 2001 (current benchmark 85%). Desired behavior regarding feeding of colostrums is not prevalent as revealed by qualitative studies - colostrums is discarded and wet nursing is practiced.

Exclusive breastfeeding up to 4 months of age



Trends in Exclusive breastfeeding



The change in protocol of breast-feeding exclusively up-to 6 months of age is being communicated to the mothers for the last 10 months while the MOH protocol is to breast-feed exclusively for "4-6 months". The diagram above shows a sharp fall in exclusive breast-feeding after 4 months of age. **There is a need for the community to hear the same message from everyone.**

The proportion of children started on appropriate complementary foods at six months of age has increased from 42% to 79.9%.

While the KPC shows the increase in the percentage of children started on complementary feeding at 6 months, the focus group discussion with mothers during the review revealed that the frequency of feeding is insufficient. The GSS needs to stress more increasing the frequency of feeding.

Vitamin A deficiency

Because of its demonstrated impact on child survival, vitamin A intervention is the priority of the BRICS Project. Both first Annual Review and Mid Term Evaluation recommended increasing the Vitamin A coverage. Vitamin A supplementation can reduce mortality in children between 6 and 59 months of age by 23 to 34%. Supplementation of vitamin A along with measles immunization, as well as biannual

vitamin A supplementation for children upto 3 years of age is being done by the MOH and the GSS.

Documented benefits of Vitamin A are:

- Improved VA status of deficient children aged 6months to 59 months dramatically increases the chances of survival

The Review Team found missed opportunities for giving vitamin A supplement along with measles vaccination in a few cases. It is evident that increased coverage of Vitamin A reduces the risk of mortality from Measles by 50%, and from Diarrhea by 40%.

The KPC finding showed 74.9% of children aged 11-23 months in the direct impact area were given a card documented dose of vitamin A in the last six months Though the coverage has increased since last year, it falls short of the current years benchmark (80%).

Vitamin A supplementation in pregnancy and post-partum is not being done as recommended by the MTE because of the current MOH policy. However, efforts are being taken in this regard with the UNICEF India field office. It is hoped that a pilot test in this area will be initiated in the fourth year of the Project. This is quite important as a recent study suggests that preventing VAD of women before and during pregnancy greatly reduces (44%) their risk of mortality and morbidity around the time of childbirth, probably through increasing resistance to infection.

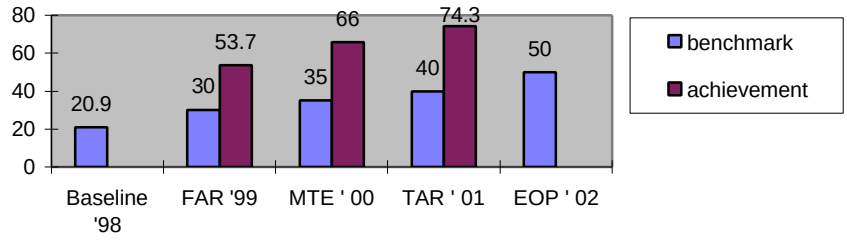
Increased coverage of Immunization

Child immunization is one of the most cost effective public health interventions for reducing child morbidity and mortality. Essential elements of the programs are coverage, surveillance, quality and polio vaccination.

The KPC survey showed that full Immunization coverage of children has increased from 20.9 % to 74.3 % and the TT coverage amongst the pregnant women has increased from 5.6 % to 85.9%. DPT I -III drop out rate has reduced to 11.4%. Measles coverage has increased from 53.6% to 74.3%. (See appendix). This year's KPC survey also considered history based coverage but found it lower than the card documented coverage rate.

This is really commendable to achieve this in three years. This reveals the demand the BRICS project was able to create in the community and also make the services through MOH available with in the community.

% Children 11-23 months who are fully immunized



Ensuring provision of the potent vaccines is an important component of an immunization program. The provision of ineffective vaccine is worse than providing no vaccine at all because ineffective vaccination damages the community's confidence in the immunization program. The increasing wild polio cases in India show that inspite of OPV doses being given, numbers of polio cases are increasing. Inefficient vaccines subject the child to the inconvenience and risks of vaccination with out benefit and mark the child as having been vaccinated, therefore precluding effective vaccination in the future. Contamination or poorly maintained vaccine is also more likely to cause reactions and illness than is pure and well maintained vaccine.

The review team found that the vaccination technique and sterilization practices were risky. Refer the table given below. ***Project needs to immediately intervene and improve on this.*** Diseases acquired through unsafe injection practices range from infections with blood borne pathogens (hepatitis B and C virus and HIV), bacterial infections resulting in abscesses and septicemia, to traumas resulting in paralysis, and rare hemorrhagic fevers. In addition to unsafe injections there are needle-stick injuries and injuries due to improper medical waste disposal, which may increase the incidence if some of the same diseases (e.g. hepatitis B) that immunization programs try to prevent.

`Table. TAR Observation of 74 Immunization Sessions - Beruarbari, Chilkahar and Bansdih Blocks

Indicator	**Findings**	**%**	**Comment**
Open	72 of 74	97	
ANM Present	72 of 74	97	
Ice Packs Frozen ½ Ice Cold Water Warm Water	 15 of 53 24 of 53 14 of 53 0	 28 73 26	Cold chain maintenance risky
VVM	52 of 53	98	
Vaccines Adequate BCG DPT	 39 of 54 53 of 54	 72 98	 Ample opportunity for missed immunization

OPV Measles TT	53 of 54 42 of 54 53 of 54	98 77 98	
Technique Sterile needle/syringe Correct Volume Correct site Told to Return	 85 of 107 93 of 107 92 of 107 44 of 70	 79 87 86 62	Techniques and sterilization risky
Exit Interview Know why come Injection Told side effects & Rx Told when to return Unsatisfied with ANM	 69 of 70 63 of 70 19 of 70 44 of 70 67 of 70	 98 90 27 62 95	

Safe injection practices include using a clean work space, hand washing, using a sterile needle and syringe for each injection, assuring sterile vaccines and diluents, and also skin cleaning and appropriate sharps and waste collection and disposal to minimize needle – stick injuries and re-use. Health workers often replace needles but reuse the syringe. The latter may contain tiny amounts of blood or body fluids and therefore may have pathogens that both contaminate vaccine vials and transmit disease.

Whatever type of injection is used, programs should ensure that there are fail-proof systems in place to ensure that needles are disposed off at minimal risk to the client, provider and the public. Programs should consider introducing auto-disposable syringes. However, any decision to do so requires special attention to disposal issues.

Another great concern of the review team was the maintenance of cold chain. Although the cold chain in the direct impact area Beruarbari is adequate, it still remains risky in the other pilot testing blocks. Project has taken steps to improve the quality of cold chain maintenance in the district. Review team commends the efforts taken by the project to consider the issue seriously. For the first time, all the PHCs of the district were brought to the negotiating table along with the district CMO, SMO and UNICEF field office to look into permanent and feasible solutions to the cold chain problem. A multisectoral approach has been worked out with the assistance of the MOH and UNICEF and is in the initial stages of implementation.

Diarrhea and Pneumonia case management

KPC survey did not look into the indicators related to the essential care of the sick child. However the KPC was able to capture that 87.5 % of mothers of children age < 23 months knew at-least two signs of illness in children that would necessitate treatment.

Sub Result: increased coverage of the essential care of the sick child however cannot be neglected. IMCI is the good approach to deal with this sub result. IMCI is not yet been adopted at the national level, however BRICS can play a role in advocating for the

adoption of the approach. With collaboration of WHO, State and District health staff, BRICS may assist with the early implementation activities. Some of the PHC doctors and the BRICS staff are already trained as lead trainer for training Basic Health Workers on IMCI.

The project has begun training the basic health workers (RMPs and ANMs) on IMCI. However the review team was not able to review the BCC session on IMCI, or talk to the PHC doctors who were trained on IMCI, as how they are using it. BCC material is also developed to be used by the GSS in educating the community. The project is in the process of implementing the community based IMCI.

The project should concentrate on developing IMCI action plans and collect the baseline data. Program activities to strengthen elements of the health systems and to design and develop community-based strategies should proceed before facility based activities.

Birth Spacing

Child spacing is a key component of basic health services because it benefits the health and well being of women, children, families and communities. By preventing closely spaced births or births to very young mothers, infant, child and maternal mortality can be reduced. It is essential that women and men have access to child spacing so that they can determine the number and timing of their children and promote better maternal and child health. Quality child spacing services ensure that clients are fully informed about the range of contraceptive choices available, how they work, and their success rate used correctly.

Babies born less than two years after the previous child are twice as likely to die in the first year of life than those born after an interval of at least 2 years. Even if these infants survive the first year, they are 2.5 times more likely to die before the age of five than children whose births were spaced at least 2 years apart. Closely spaced pregnancies increase the chances of women having low birth weight babies, increase competition for limited resources between siblings, and increase the risk of transmission of infectious diseases.

Findings of the KPC were remarkable. Only 10% of mothers with children aged 0 to 23 months were pregnant at the time of the survey (confidence interval 7.8% to 12.8%). This is marginally lower than last year's figure of 11.9% and is an encouraging finding that suggests that the combined efforts of the MOH, BRICS and private stakeholders towards birth spacing is bearing fruit.

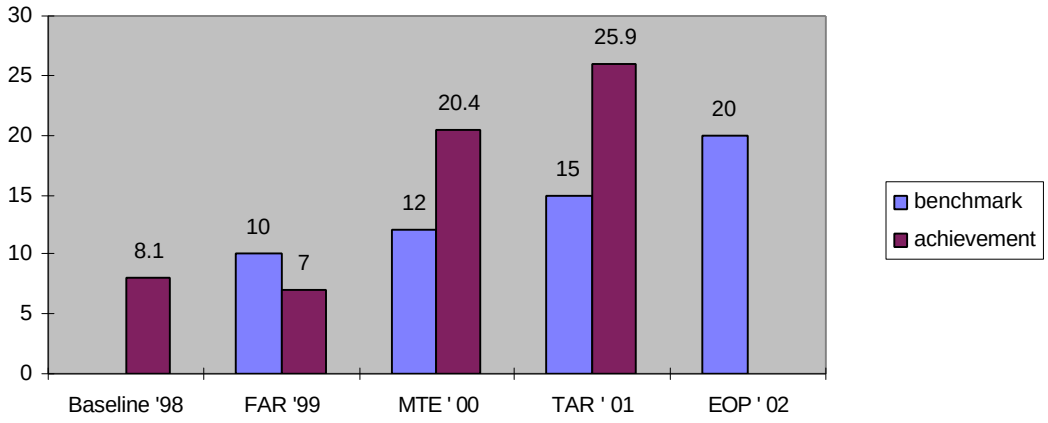
23.4% of mothers who did not want another child in the next two years, or were not sure, were using a modern method of contraception. This is much higher than the benchmark of 15% for the year and higher than last year's achievement of 20.4%.

Although the progress is good, there is much to achieve. The important question is to sustain the efforts in achieving the child spacing results. The project should develop some community based behavior change strategies particularly keeping the following in mind:

- Religious, cultural and ethnic beliefs about children, contraception and the role of women;
- Key decision maker in the home
- Local words and terms for discussing pregnancy, contraception and sexual related subjects. The project should focus on imparting sexual education to the adolescent boys and girls.
- Affordability of services and willingness to pay, and how it varies over time.

The project should also consider and explore the possibility of the social marketing of the contraceptives.

Usage of contraception among those who desire no more children



Increased Reproductive health coverage

KPC shows that the percentage of mothers who consumed at least 90 IFA tablets during previous pregnancy have increased from 29.1% to 32%. Even though the current MOH/ UNICEF policy is consumption of 100 or more tablets, only 72% of the above had taken all the 100 tablets that were supplied to them.

Trained health providers have attended 22% of deliveries in the past year. This is the same as this year's benchmark. Seeking the assistance of trained TBA has shot up from 0.7% last year to 7.3% this time around.

Essential care of the newborn

The TBAs are the point persons in the community to deliver this care to the beneficiaries. Training and support of these community-based attendants has begun to bear fruit as evident from the stories heard from the mothers and from the TBAs themselves.

The most significant aspect in this training is resuscitation of asphyxiated babies. Many a TBA has proven that primary measures undertaken without delay can prevent deaths due to birth asphyxia. The TBA kit provided to them after training has the necessary equipment to provide essential care.

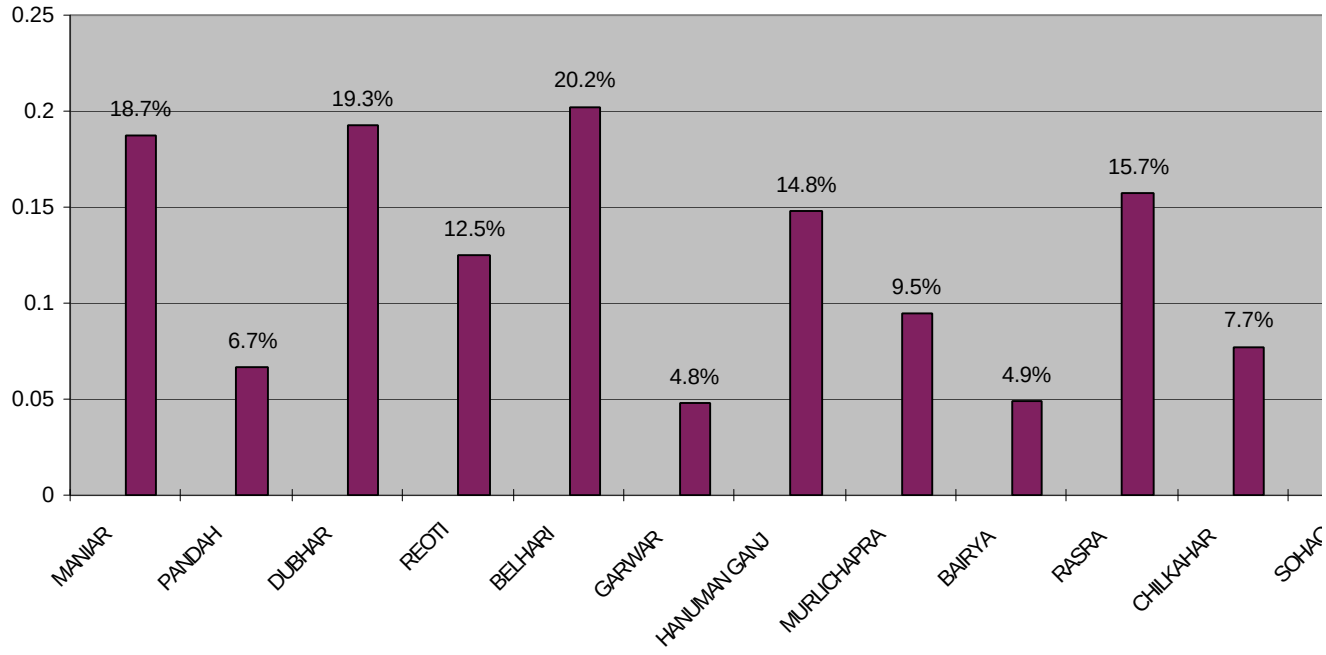
Focus group discussions done with the trained TBAs in the direct impact area as well as in the other 16 blocks of the district showed sound knowledge among these illiterate women on various issues like referral protocol. 85% of TBAs that the teams spoke to (in 6 focus groups) were able to recall all criteria for referral before, during and after delivery (for the mother and the baby) and elements in home based neonatal care.

The project has also put in place a system to track babies born with low weight in order to obtain baseline information, which will help in the design of a package for comprehensive care of neonates.

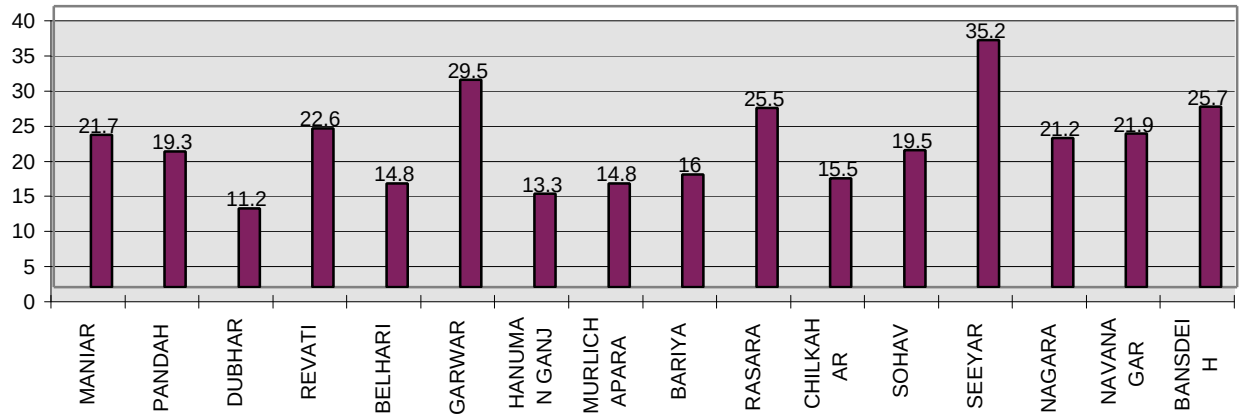
Development of baselines for the District

In a concerted effort along with all the stakeholders, quantitative baseline surveys (KPC) were done for all the 16 blocks of the district that comprises the Project's indirect impact area. This massive exercise in terms of human resource and logistics has resulted in a wealth of information block wise for Ballia. (Please find details in the section on Capacity Building).

Immunization Details for 16 blocks of Ballia



Current night blindness among Mothers in the district



10. Support Systems

Management

Management is too broad a field to be addressed during the Third Annual Review, but certain themes of management are crucial for the efficient implementation of the Child

Survival Program. The review team looked broadly in the area of strategic management, planning, managing the team with appropriate leadership and communication skill, partnership and the resource management.

BRICS is managed by ADP Ballia, which is directly monitored and supervised through various technical and financial resources from World Vision North Zone (Delhi), the WV National Office (Chennai), the WV International Regional Office, and WV US. The Regional Health Advisor, Dr. Sri Chander, had provided technical assistance since the project's inception to its current state. Dr. Chander visits the project once in every four months. Telephone and e-mail contacts have been more frequent.

Some of the activities related to technical assistance have been, accessing technical information from WHO, USAID, SIFPSA, UNICEF, CEDPA, SEARCH, SWATCH, administrative and management support to ADP Ballia in terms of staff recruitment, infrastructure development, logistics and finance, strengthening management through capacity building of the core team (leadership and team building skills), learning monitoring and evaluation (programmatic and financial) through capacity building courses, providing a framework and strategy for the evolution of a focused sectoral project (i.e. child survival) within WV's ADP approach.

While strategic management, planning, resource management and communication of BRICS are excellent, the partnership and the team management need to be strengthened in order to reduce the stress level. Williams, 1997 describes that the behaviors or attitudes of managers who demonstrate effective leadership skills fall into two broad categories; providing direction and providing support. It is difficult to establish absolutes in this area, but effective leadership entails a constant balancing as summarized in the table below:

		Directive Behavior	
		Low	High
Supportive Behavior	High	Supporting	Coaching
	Low	Delegating	Directing

Human Resource

The central resource of any project is its staff. While organizing work, developing efficient systems, ensuring quality processes, monitoring activities and performance, problem solving are all essential activities of the Team Leader who heads the staff looking after both the ADP and the BRICS program. Apart form managing both public and the private funds, track large and small expenditures, he has to establish relationship with the key stakeholders and the people (staff and the community) on which the process and the output of the project depends.

The CSP Manager, who provides the team leader with technical inputs, helping to develop technical and training component related to health, assists the team leader. The review team commends high commitment and dedication of both the team leader and the CSP Manager.

There is a CORE team in place in the project, comprising of Monitoring and Evaluation Officer, Development Coordinator, Training Coordinator, and Finance Officer other than the Team Leader and the CSP Manager, who jointly coordinates the CORE Team. The function of the CORE team is to be part of the strategic planning of the project.

The backbone of the project is highly skilled CDOS/LCOS, who are now functioning as support – a- visor to the GSS. Many of them are now the lead trainers of various technical components of the project. In all there are 24 staff working in the project.

Major achievement of the project is establishment of harmonious working climate, tremendous increase in the staff capacity on conceptual as well as technical issues. With a limited number of human resources the project needs to be commended on scaling up in the entire district.

However the major turn over of the staff remains a major challenge. Project needs to come up with some strategies for retaining the staff. Reduced number of human resource puts the existing staff in a high level of stress. Lack of second line also increases the work pressure on the management, giving less room for creative thinking. The existing vacancies should be immediately filled and with the project scaling up district wide the number of positions need to be increased.

Health Management Information System

Community-Based Recording System

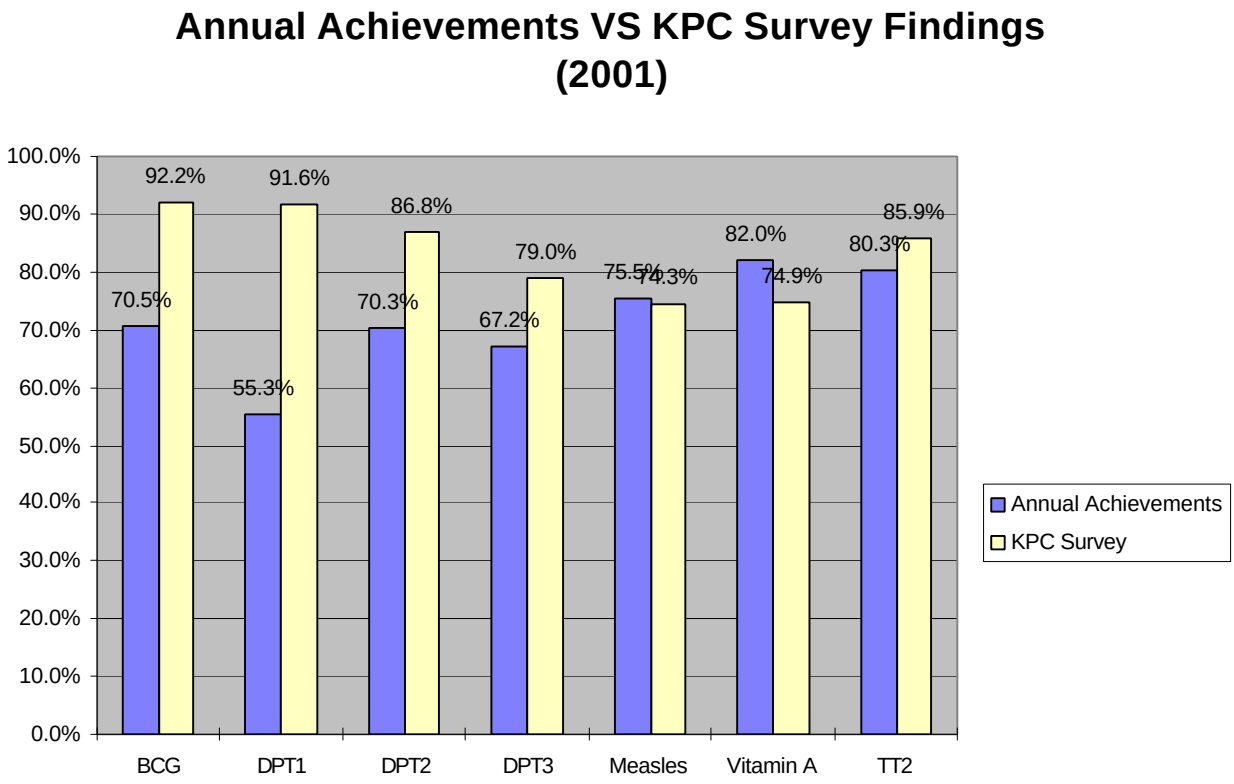
Birth, deaths, and pregnancies are reported in Ballia district through the community based EPI, and pregnancy register, which have been instituted by the BRICS project, and maintained by GSS to identify children, and women, who need follow-up health services. Such services include immunization of children, TT vaccination, iron tablets, education on breastfeeding, and complimentary food. Reproductive Child Health (RCH) cards are also being provided by the BRICS project to the PHCs who have not received it for number of years now.

The registers are maintained by GSS, who belong to the same village, this ensures the accuracy of the information. The plan is to gradually transfer the maintenance to the community institutions.

The review team reviewed the sample of these registers in all the blocks. The quality of maintenance was found to be a big issue. Although the register maintenance was good in Beruarbari block, but the maintenance in any other block raises the question on the quality. The graph above shows the gap between the coverage through the registers and the KPC findings.

Coverage is another issue to be looked into. The review team was in the view that it is practically very difficult for the GSS to cover the population they are responsible for. This raises a big question on the coverage, which was quite evident from the graph being shown below.

The review team has recommended to make the supervisor layer stronger to support the GSS for the maximum coverage.



REPORTING SYSTEM

GSS uses a monthly reporting from in which they compile the data from the village-based registers. The supervisors further compile these reports. This helps them to plan their supervisory visits in improving the program quality and coverage. NGOs also compile their reports in the similar fashion.

CBDDS groups are formed with ANM, Teachers, TBA and GSS. The groups members have been trained to report all known deaths of women 15 - 45 years, Newborn deaths (28 days) and all children under 5 to BRICS field staff. The project staff then carries out verbal and social autopsies. Social autopsies are conducted with the Mahila Mandals, panchayat members and family members to sensitize them that these deaths could have been prevented.

LOW BIRTH WEIGHT MANAGEMENT

One of the major achievements of the BRICS project is the special monitoring tool designed to track low birth weight children. It has been tested in Beruarbari Block. The data was not significant enough to analyze at this point of time. This tool will be introduced District wide reduce low births.

BRICS project has made linkage between TBA and GSS. TBA has color-coded scale which she uses during delivery and recode it on her delivery assessment tool, which has only pictorial mark. GSS read the mark and reports it in her monthly report, and visits the family to advise the management of low birth child.

MONITORING TOOLS

Different monitoring and assessment tools are using to validate the data of pregnancy, EPI and family planning register and for continuous improvement of program quality and coverage.

ANALYSIS REPORT AND DATA

All the data generated is managed in the EPI INFO Software. The analysis is used by the program staff to give the feedback to the MOH, the, GSS, and the community to improve the quality of the program.

Finance

AID GRANT NUMBER: ***FAO-A-00-98-00041-00***

Description	Grant Budget	Prior Actual	Current GTD Act.	Act. Current Qtr	Total GTD	Balance Grant
	A	B	C	D	E	F
AID Funding						
Salaries	180260	46671	29158	7367	83196	97064
Travel	108945	31618	22600	3953	58171	50774
Training	182129	48935	53570	36495	139000	43129
Professional Fee	20200	9183	0	0	9183	11017
Supplies & Materials	43110	13365	11842	6395	31602	11508
Capital Equipments	12932	12932	0	0	12932	0
ODC	66116	29224	21248	12085	62557	3559
Sub-Total	*613692*	*191928*	*138418*	*66295*	*396641*	*217051*
Local Contribution WV India	*0*	*0*	*0*	*0*	*0*	*0*
Total Field Funding	***613692***	***191928***	***138418***	***66295***	***396641***	***217051***

Match Funding						
Salaries	0	0	0	0	0	0
Travel	0	0	0	0	0	0
Training	0	0	0	0	0	0
Professional Fee	0	0	0	0	0	0
Supplies & Materials	360753	0	0	0	0	360753
Capital Equipments	18147	18147	0	0	18147	0
ODC	0	0	0	0	0	0
Sub-Total	*378900*	*18147*	*0*	*0*	*18147*	*360753*
Local Contribution WV India	*100000*	*85782*	*0*	*0*	85782	14218
Total Match Funding	***478900***	***103929***	***0***	***0***	***103929***	***374971***

Column (A)	Life of a grant Budget
Column (B)	Actual from inception to the end of the prior FY
Column (C)	Actual for current fiscal year till prior quarter
Column (D)	Actual for current quarter
Column (E)	Sum of column (B)+(C)+(D)
Column (F)	Balance (A)-(E)

11. Issues identified by the MTE and the Project Response

FOLLOW UP RESPONSE TO THE RECOMMENDATIONS OF THE MID TERM EVALUATION

RECOMMENDATIONS	FOLLOW UP RESPONSE
External members of the evaluation team commend the community, Government, and World Vision staff for the progress made in the implementing the project, especially the acceleration in the last six months.	Project also thanks the MTE team for providing guidance to the staff, and also providing opportunity for learning.
8b. Develop a behavior change communications plan indicating target audiences, messages, methods, and frequency (including availability of necessary audio/visual aids	The BCC Plan was formulated after discussions with BRICS staff and an in-country consultant group based at Lucknow. It was decided that the method of communication would be flip charts, and there would be separate flipbooks for each of the 7 technical intervention areas, with the pictorials and text facing each other. The text was developed in Bhojpuri, the local dialect, with the help of local staff and schoolteachers in the community The materials were field tested with the Community Health Workers (GSS) as well as with the women in some villages, before they went for final printing. These materials were well appreciated by the USAID local mission.
8c. Instill in staff and partners a long term orientation towards partnership and develop follow-on proposal	Project staff and the partner NGOs, MOH are all well trained in the concept of partnership. A strong network has already been established, which do the District Authorities and the Ballia CMO recognize. ADP Ballia provides the secretariat for the partnership. This will help towards the sustainability of the project. The project has plans to request USAID for no cost extension and will submit the follow on proposal after 4th year of the project.
8d. Develop a plan to expand from the current 53 villages to all 83 villages by the end of the third year of the project (9/30/2001	The Project is at present operational in 80 villages. In the other 3 villages, the religious fundamentalist group has deferred implementation of project activities owing threat to physical safety of the staff. Discussions are going on with the leaders of these villages in order to begin activities. Situation seems to be positive as these leaders participated in the RCH training conducted for Panchayats by the Project.

8d. Test at least two different expansion models	The project is testing three different models at present. ICDS model in the Chilkahar block, where the ICDS worker plays the role of GSS and project does not provide them financial assistance. Panchayat Model is being tested in the Bansdih Block where the Panchayat selects the GSS, and they provide them financial assistance. In the rest 14 blocks the NGOS model is being tested. These models have been discussed in greater detail under section..
9a. Continue to expand the public and private partnerships for birth spacing (e.g.SIFPSA)	Expansion in Ballia is on SIFSA's planning for the next phase. Already partnership with them is established for ANM's training on family planning counseling. Nevertheless 14 Lead Trainers have been trained by SIFPSA certified facilitators who now train RMPs in all blocks in Principles & Methods of Family Planning. These RMPS then provide services to the community and also become the depot holder.
9b. Request assistance of Abhay and Rani Bang in replicating their strategy for newborn care in Ballia District.	The project is not successful in getting technical assistance of the Bangs so far. Although the project has made several efforts to contact them, and a team also made a visit to their project. Nevertheless the project has made its own efforts by revising the curriculum of TBAs to include essential care of the newborn and referral. A newborn information card has been introduced which will be filled by the TBA at delivery and passed on to the respective GSS.
9c. Institute postpartum Vitamin A upto 4 weeks post delivery	Post Partum Vitamin A supplementation is still not the policy of the Government. Several meetings were conducted with the UNICEF technical officer to seek their assistance in the issue. District CMO has agreed for conducting a pilot testing of post partum Vitamin A that will be technically supported by UNICEF. Post partum rounds will begin in Beruarbari block once supplies from CIDA arrive
9d. Install recently arrives transformer at PHC and establish cold chain. Explore current and potential vaccine time -place studies to shorten time between pick up and use.	The transformer has been installed in Beruarbari PHC, which has improved the quality of the cold chain to the greater extent. Cold chain assessment was conducted District wide and the action plan was developed. Vaccine van of the CMO office has been repaired by the project. This will be instrumental in

	providing vaccines at the sub centers on Wednesday morning, and thus maintaining cold chain at the sub center level.
9e. Provide training in case management of childhood illnesses to community based medical practitioners	Although project was not able to achieve much on this, but sincere efforts are made towards it. IMCI has been adapted and incorporated in the GSS training curriculum. 7 Medical Officers have been trained as lead trainers in IMCI to train the GSS and RMPs. Further trainings will be conducted in the fourth year of the project.
9e. Explore with the district hospital (men's) the feasibility of establishing an ORT corner at the hospital for training district personnel.	Approval has been obtained from the Medical Superintendent for establishing the ORT corner. They are yet to identify the PHN who can be trained in managing ORT corner. The project plans to send the identified staff to ICDDR Bangladesh.
10b. Define clearly the role of GSS (record keeping, depot holder, and messenger) and LCO/CDO as mentor and support-a-visor	The project organized a strategy-planning workshop right after the MTE where the new roles of LCO/CDO were discussed. There are no overlapping and confusion in the roles now. The project management also provided support to them in their new roles. GSS have also been oriented on their roles through review training and continuous support.
10d. Fill vacant positions immediately	Staff vacancies in Beruarbari block have been filled.
10d. Establish a day care facility to fill in this need.	Due to relocation of staff, the relevance of this issue is lost.

12. Challenges and Constraints

1. Improving Sterilization techniques and cold chain

Although the cold chain situation in the Beruarbari has improved much beyond the expectation, it still remains a challenge in the other blocks of the District. One thing for which BRICS could be remembered and will leave in place will be the improvement in the cold chain.

Another challenge which is a cross cutting issue throughout the District is to improve the sterilization techniques. Much emphasis needs to be given on this, in order to reduce the mortality. The sterilization is risky as found by the review team.

2. Intensifying the work in two model blocks namely Bansdih with Panchayat and Chilkahar with ICDS

For the review team it was too early to comment on these two models, but definitely the end of the project review team will look into this. The great challenge that lies ahead of the BRICS project to come up with the model which is cost effective and could be acceptable by the other ADPs, who do not have the luxury of the USAID, support and money, but still be able to successfully replicate lessons learnt and best practices.

3. Ensuring Quality and coverage in maintaining the village based EPI and Pregnancy registers

Though BRICS has achieved setting up the community-based registers in all the villages of the District, but yet a major challenge is maintenance of the quality of these registers, and information to be utilized by the partners for decision-making. Except in Beruarbari, the registers were not maintained properly, and the coverage was questionable. The comparative graph clearly shows a wide gap between the coverage through KPC and the registers.

4. Communicating the uniform Behavior Change messages in light of the new protocol

Protocols related to breast-feeding and the consumption of iron folic acid has been revised recently. The messages related to the revised protocol needs to be communicated to the community in order to ensure the desired behavior change.

5. Coordination between the ANMs and the GSS in across the blocks

Although the project is able to recruit the GSS through out the district, the coordination between the GSS and the ANMS is still the challenge. For the effectiveness of the program, they need to work in close coordination, so that the efforts are not duplicated, and the maximum people are benefited.

6. Developing the strategy and mechanism to provide support to the supervisors in the various blocks to ensure the quality.

A GSS is covering almost a population of 5000. It is practically not possible for the GSS to cover villages she is responsible for. Some of them do not even cover their own villages. NGOS are not able to supervise all of them. There is a missing layer of the supervisors,

between the NGO chief and the GSS. These supervisors are the responsibility of the NGOs as per the partnership agreement. The BRICS project needs to build their capacity and also look into various mechanisms to make this supervision mechanism strong.

7. **Using the BCC materials and transfer the messages to the mothers**.

BRICS has developed integrated BCC materials and distributed it to the entire GSS district wide. The challenge is to ensure that these materials are being used by the GSS, and are not kept in their homes. This will help in tracking the behavior change in the community.

8. Support a vision to the NGOs.

Expansion in the District itself was a challenge, which the project was able to meet. The project has identified six local NGOs, and developed partnership with them, to replicate some of the BRICS activities. The challenge for the project now is, with its limited human resource provide support – vision to these NGOs. The project should look into releasing few of its staff fulltime to provide support a vision, and recruit new field staff in Beruarbari block, whose capacity should be build.

9. Turn over of the staff

Remoteness of the project location has been instrumental in the rapid turn over of the ADP Staff. As staffs are placed in the sub centers and sometime in hostile conditions, they need opportunities for being counseled and offered moral support. Visits of Zonal Office staff can effectively meet this need where the staff can be given space to ventilate their feelings, frustrations and so as to prevent any eventual breakdowns. This process can thereby enable the staff to have renewed commitments and be reenergized. In keeping with this factor, one-day retreats and recreation time could be organized on a quarterly basis for them. Motivation and the mental health of the BRICS staff are vital for its continued success.

13. Changes in the Project Design

There are no substantial changes from either the approved agreement or the DIP, which will require a modification to the cooperative agreement.

14. Areas for Technical Assistance

- **New Born Care**

  There is a need to move from essential care to a comprehensive care package for the neonates. BRICS is currently collecting data on the low birth weight neonates, but requires external technical assistance in designing a comprehensive package.

- **Community Based Disease and Death Surveillance**

  ADP is in the process of forming and strengthening a Health Development Committee in every village in the direct impact area, as a step towards sustainability of program benefits. These village based institutions need to be trained in initiating quick and appropriate action on data collected in the community. Technical assistance will be required in this area.

- **Post Partum Vitamin A**

While support is needed from agencies like UNICEF in advocating for this project, technical help is also required in designing and conducting this operational research.

- **Information Dissemination**

Lessons learnt, promising practices demonstrated and documented in BRICS field area wait to be disseminated through publications and workshops. Brics require technical assistance in conducting this.

15. Key Recommendations

1. Ensure proper sterilization technique and the cold chain at the ANM level

Review team commend the BRICS efforts in conducting the cold chain assessment in all the Primary Health centers in Ballia District and there after conducting the follow up workshop in maintenance of the cold chain. This has helped in some extent improving the cold chain at the PHC level. The review team would like to re-emphasize MTE's recommendation of conducting a study to reduce the time gap between the distribution and delivery point. The ANMs in all the blocks needs to be trained on sterilization techniques and joint supervisory visits with the Medical Officers should be conducted to review the behavior change.

2. Reinstate the concept of integration in the program.

Integration is an important issue to address the sustainability of the project. The ADP is a long-term programme where as the CSP was nestled with in the ADP and is a short-term intervention. It was visible in the review that the CSP component and the ADP need to be more in harmony in order to achieve the overall objectives. Though there is financial integration the review team feels that there needs to be more integration at the programme and the management level.

3. Children tracked by the BRICs since its inception should now be enrolled in the Early Childhood Care and Development.

The ADP believes in the total well being of children. Through CSP, the ADP has invested its time and resources in tracking children since pregnancy, it would logically follow that the children now needs early childhood care to achieve age specific development milestones in order to have longitudinal impact in the life of children.

4. Intensify the work in the two pilot testing blocks

The whole idea of working on two different models is to find out the better model for further replication and mainstreaming. While reviewing the work it was found that it is too early to assess which model is working well. However in order to assess the efficacy of these models in the final evaluation the work needs to be intensified in these two blocks.

5. Conduct CQI workshop for the NGO partners and the MOH staff

The quality of programming and the health services rendered by the MOH were not up to mark. It is recommended to conduct a CQI workshops to improve the quality and ensure continuous quality improvement.

6. Develop a strategy for mainstreaming in 4 UP ADPs.

The mandate of the project is to mainstream activities in the 4 UP ADPs by the end of fourth year. Although some efforts have been made in capacity building of the staff in these ADPs, there needs to be concrete plan developed to mainstream the BRICS activities in these four UP ADPs.

7. Conduct OD workshop for the partner NGOs.

The NGO partners at present can be classified in to two major categories: One category is of those who are well established while the rest are in the process of establishing themselves. OD exercises needs to be conducted for both the groups in order to build their capacity.

8. Re-look into the operational strategy of the partnership, so that it is in line with the strength of the NGOs, giving scope for innovation and yet fulfill the expectation of the BRICs.

The NGO were selected for partnership based on their strengths so that BRICS could capitalize on these strengths to mainstream in the entire district. However there was a general feeling among the NGOs that their inherent strengths are not being optimized thereby reducing their ownership of the CSP activities especially in the cases of the established NGOs. The operational strategy could be reviewed giving in line with the NGOs strengths giving room for innovation and mutual resource sharing.

9. Address staff stress related issues at all levels.

The staff currently are going through high levels of stress due to the work overload, staff security issues and turnover of staff. Activities related to stress management; creativity and work prioritization needs be conducted in order to avoid staff burnout. The staff structure needs to be re –looked, and if necessary, create more positions to reduce workload. The minimum staff strength required should be met.

10. Consult with the finance department in the Zone/ National Office regarding FCRA policies and the transfer of funds to the Partners as reimbursement grant.

NGOS raised the issue of keeping photocopies of vouchers with them for audit purposes because the current practice of grant reimbursement is through demand draft or cheque. This gets reflected in their bank accounts, which needs to be audited. The review team was not sure whether it is in line with FCRA rules and regulation. As this is a very important issue Zonal Office and National Office should be consulted to sort out the financial implications for future partnership.

11. Fill all the vacancies

The organogram presented clearly shows that there are still many vacancies to be filled. The review team re emphasize on the MTE recommendation to fill in the vacant positions.

Appendix I TAR Participants List

Ballia District

Dr. O.P. Singh:		Chief Medical Officer (Ballia District)
Dr. Chaoudhary	:	Deputy Medical Officer (Ballia District)
Mr. Balram Sharma :		Chief Statitian (Ballia District)
Mr. M.E. Khan	:	Training Officer (Ballia District)
Dr. D.P.Singh :		MOIC PHC Bansdih (Ballia District)
Dr. Ashok Kumar	:	MOIC PHC Beruarberi (Ballia District)
Dr. Gupta	:	MOIC PHC Chilkahar (Ballia District)

WHO

( )	:	Surveillance Medical Officer

NGO Partners

Dr. Mazhar A Rashidi	: Director, PRATINIDHI, Belthara Road, Ballia
Dr. Srivastava	: Director, Naval Shikshan Sansthan, Ballia
Fr. Abhishikt Anand	: Director, Purvanchal Gramin Chetna Samiti
Tej Bahadur Singh	: Director, Subhash Memorial Manav Seva Sansthan
Jitender Chauhan	: Director, Gramothan Seva Ashram , Ballia
Ghanshyam Singh	: Director, Gramodhyog Seva Samiti, Ballia

World Vision North Zone Office, New Delhi

Ms. Sushma Cornelius, Operations Manager,
Mr. Subodh Kumar, Monitoring & Evaluation Officer,
Ms. Manju Mathews, Program Officer

World Vision Myanmar Office

Dr. Ivan Wold Vision Mayanmar

World Vision India Chennai Office

Bradely Thompson, Monitoring & Evaluation Associate
Sashmita Swain Monitoring & Evaluation Associate

Area Development Program Aparajita

S. Jayakumar- Manager

ADP Staff

K.A Jeyakumar	Team Leader
Dr. Beullah	CSP Manager
Anthony John	M&E Officer
Lini Mathew	Accountant-1

Elwin R. Dayal	M&E Coordinator
Akbar Masih	Development Coord.
Nitin Kumar	Intern Admn Asst
Anant Masih	Polio Coordinator
Shailender	CDO
Ruby Kumar	PHN
Kamal Kishore Singh	Network Secretary
Anita Joshua	PHN
J. M. Khalkho	CDO
Franco David	Training & SRS Asst
Amit Hamilton	CDO
Surinder Kumar	CDO
Deepak Kumar	CDO
Sanjay Masih	CDO
Uttam Das	CDO
Sunita Kumari	LCDO
Rajeev Kumar	Driver-1
Suraj Kumar	Driver-2
Anita Mathews	PHN
Naveen Sahu	Accountant-2
Naveen Nischal Kumar	CDO
Stephen Cross	CDO

Appendix II Third Annual Review Program ScheduleOctober 2 to 6,2001

Tuesday , October 2,2001

2:00 PM to 10:30 PM Presentations by the BRICS staff and the Partners

Wednesday , October 03, 2001

10a.m. to 1p.m. Field work to observe Immunization
2p.m. to 5p.m. FGD with community, Dai, ANM, GSS, RMP in respective blocks
8p.m. to 11p.m. Debriefing on respective field work :

- Areas for improvement
- Sharing of observations
- Areas of great concern
- Sharing of Lesson learnt
- Next day work plan

Team 1 (Bansdih Block)
Sushma, Dr. Mazhar, S Jayakumar , Sasmita, Jeetender, Sanjay Masih, Khalko, Shailender, Franco, Ruby, Stephen, Anthony, - Panchayat model

Team 2 (Chilkahar Block)
Subodh, KK Singh, Beulah, Ghanshyam, Dr. Shrivastav, Elwin, Anant, Tej Bahadur, Uttam and Sunita, Anita Mathews- ICDS

Team 3 (Beruarberi block)
Manju, Bradley, Dr. Ivan, KA Jayakumar, Fr. Gyan, Sanjay Singh.
Balram Sharma, Deepak, Naveen, Akbar, Kumar, Anita Joshua, Amit- Beruarbari

Thursday 04, 2001
9a.m. to 1p.m. Field work to observe health interventions in partner NGO blocks
2p.m. to 5p.m. FGD with community, Dai, ANM, GSS, RMP in respective blocks
8p.m. to 11p.m. Debriefing on respective field work NGOs :

- NGO capacity
- MIS
- Tally register
- FGD
- Observation of immunization and pregnancy register
- Community's perception for their NGOs

Team -1 **:**Sushma.Anant, sunita, uttam,stepehen, (Gramothan Vikas Ashram)
Team -2 **:**Manju, KAJ, shilendra, khalko (Naval sikshan Sansthan)
Team-3 **:**Bardley, Elwyn, ruby, Deepak (purvanchal gramin chetna samiti)
Team 4 **:**Beulah, sasmita, s. Jeykumar, Anita, Franco (Solanki Gramodhyog Seva Samiti)
Team 5 **:**Subodh, KKSingh, Anthony John, franco, anita,amit,nitin (pratinidhi)
Team 6 **:**Dr Ivan, Akbar, Amit Hamilton, naveen and Navin and sanjay (Subhash Memorial Manav Uthan Sansthan)

NGO capacity, MIS, House visit and tally the registers, FGD how community perceive their NGO

Friday 05, 2001

9:00 AM to 1:00 PM	Meetings with the Partner NGOs
2:00 PM to 4:00 PM	Staff Interviews
4: 00 PM to 11:00 PM	Review team meets to discuss the recommendations, issues and constraints.

Saturday 06, 2001

9:00 AM to 1:00 PM	Report writing
2:00 AM to 4:30 PM	Debriefing of the staff

Appendix III Summary Result Sheets
Survey Results

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT

TARGET & ACHIEVMENTS OF THE PROJECT

Indicator	Baseline Survey November 98	Year I Bench Mark	KPC Oct. 99 Findings	Year 2 Bench Mark	KPC Jul 2k findings	Year 3 Bench Mark	KPC 2001 findings	Year 3 Bench Mark	EOP Bench Mark
A. Pneumonia Case Management									
1. % mothers/caretakers able to recognize at lease two danger signs of pneumonia that call for immediate referral and treatment.	151/300 50.33%	65%	204/420 48.57%	65%	269/420 64.04%	65%	525/600 87.5% (86.5%-88.5%)	65%	70%
2. % mothers/caretakers who sought appropriate antibiotic treatment for their children under 24 months with cough and rapid or difficult breathing in the past two weeks.	77/116 66.4%	65%	104/105 99%	65%	80/92 86.9%	65%	unable to track	65%	65%
3. % children 0-23 months diagnosed with pneumonia who were treated with antibiotics according SCM protocol.	Unable to Track	10%	Unable to Track	25%	Unable to Track	40%	unable to track	40%	55%
C. Increased Coverage of Essential Care of the Newborn									
1. % of post-partum mothers trained in the care of their newborn (hypothermia prevention, low birth weight management, and the initiation of exclusive breastfeeding, prevention of asphyxia.	Unable to Track	0%	Unable to Track	15%	696/1021 68.2 (From pregnancy Register)	25%	2020/3780 53.4% (from registers and TBA records)	25%	40%
D. Increased Immunization Coverage									
1. % infants 0-11 months who have received card-documented doses of BCG, OPV3 and measles vaccines before age 12 months.	28/134 20.9% (Card)	30%	65/121 53.7%	35%	117/177 66.1%	40%	124/167 74.3% (72.6%-76%)	40%	50%

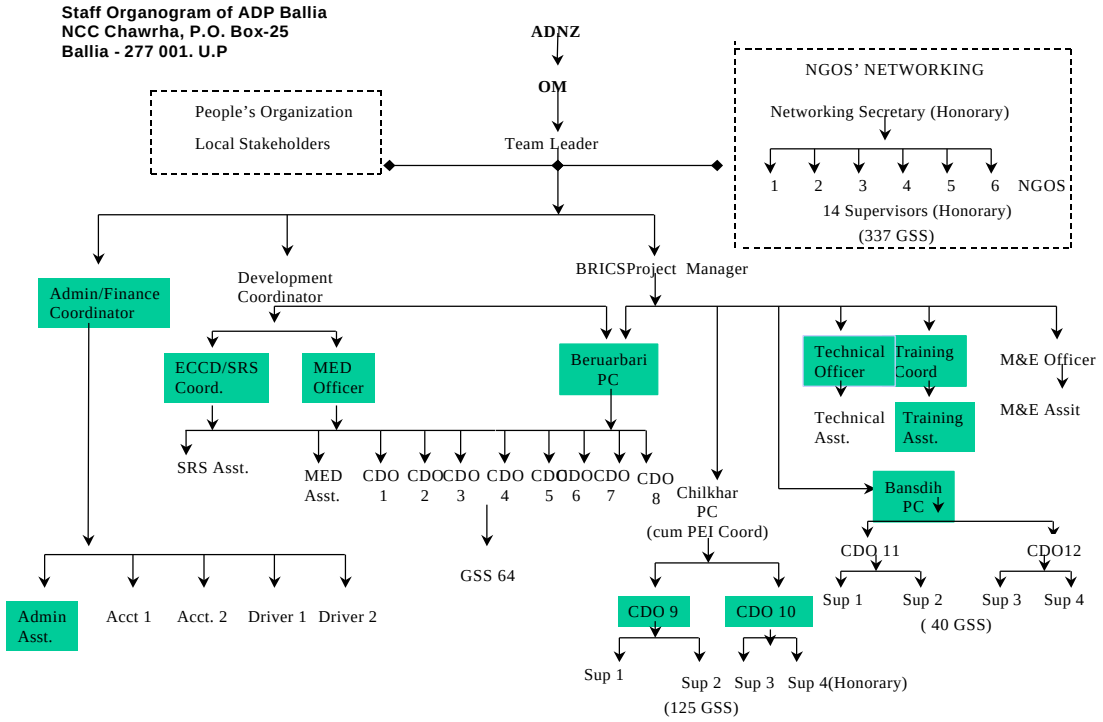
Indicator	Baseline Survey November 98	Year I Bench Mark	KPC Oct. 99 Findings	Year 2 Bench Mark	KPC Jul 2k findings	Year 3 Bench Mark	KPC 2001 findings	Year 3 Bench Mark	EOP Bench Mark
2. % of mothers with two card-documented doses of tetanus toxoid (TT2) before the birth of their youngest child <24 months	17/300 5.6% (Card)	10%	58/184 29.3%	15%	257/335 76.7%	25%	110/128 85.9% (84%-86.8%) based on recall-213/300 78.3%	25%	35%
E. Prevention of Malnutrition and Vitamin A Deficiency									
1. % infants 0-4 months exclusively breastfed in the last 48 hours.	49/64 76.6%	80%	88/105 83.8%	80%	89/97 91.8%	85%	139/150 92.7% (90.5%-94.9%)	85%	90%
2. % of infants 5-9 months who are being given solid or semi-solid foods.	17/66 25.8%	30%	29/76 38%	40%	42/100 42%	40%	343/429 79.9%	40%	45%
3. % children 9-23 months who received appropriate card-documented doses of VAC semi-annually.	10/171 5.8%	60%	44/129 34.4%	80%	127/180 70.6%	80%	125/167 74.9% (73%-76.8%)	80%	90%
4. % of post-partum mothers who received one card-documented high dose vitamin-A supplement within 4 weeks of delivery.	0	5%	0%	20%		20%	0	20%	30%
F. Improved Reproductive Health Coverage									
1. Number of target villages which have functioning village-based emergency transport schemes for obstetric emergencies.	0	5	16	15	22	30	did not track	30	40
2. % women with children <24 months who reported at least one unintended pregnancy in the last 12 months.	95/300 31.6%	30%	7/24 29.2%	30%	11/78 14.1%	25%	did not track (those pregnant now -	25%	20%
3. % of women with children less than 24	24/282		20/286		67/328				

Indicator	Baseline Survey November 98	Year I Bench Mark	KPC Oct. 99 Findings	Year 2 Bench Mark	KPC Jul 2k findings	Year 3 Bench Mark	KPC 2001 findings	Year 3 Bench Mark	EOP Bench Mark
months who desire no more children, or who are not sure, who are using a modern method of contraception.	8.1%	10%	7.07%	12%	20.4%	15%	60/600 10%	15%	20%
4. % women who delivered their youngest child in the last year have received at least 90 iron/folate tablet supplements during their last pregnancy.	11/125 8.8%	10%	43/184 8.7%	15%	226/335 67.4%	25%	97/413 23.4% (22.7%-24.1%)	25%	35%
5. % mothers who had three or more card-documented antenatal visits before the delivery of her youngest child<24 months.	5/300 1.7% *	5%	47/184 9.8%	15%	263/335 78.5%	25%	96/300 32%(31.2%-32.8%	25%	35%
6. % deliveries in the last 12 months which had been attended by a trained health provider or PHC/SC/ANM staff.	51/300 17% **	18%	121/420 17.6%***	20%	171/420 40.7%	22%	did not track 65/300 22% (21.7%-22.3%)	22%	25%

Appendix IV ADP Ballia Staff List

Sl.no	Name	Designation
1	K.A Jeyakumar	Team Leader
2	Dr. Beullah	CSP Manager
3	Anthony John	M&E Officer
4	Lini Mathew	Accountant-1
5	Elwin R. Dayal	M&E Coordinator
6	Akbar Masih	Development Coord.
7	Nitin Kumar	Intern Admn Asst
8	Anant Masih	Polio Coordinator
9	Shailender	CDO
10	Ruby Kumar	PHN
11	Kamal Kishore Singh	Network Secretary
12	Anita Joshua	PHN
13	J. M. Khalkho	CDO
14	Franco David	Training & SRS Asst
15	Amit Hamilton	CDO
16	Surinder Kumar	CDO
17	Deepak Kumar	CDO
18	Sanjay Masih	CDO
19	Uttam Das	CDO
20	Sunita Kumari	LCDO
21	Rajeev Kumar	Driver-1
22	Suraj Kumar	Driver-2
23	Anita Mathews	PHN
24	Naveen Sahu	Accountant-2
25	Naveen Nischal Kumar	CDO
26	Stephen Cross	CDO

Appendix V ADP Ballia Organogram



Appendix VI Revised Terms of Reference

BALLIA RURAL INTEGRATED CHILD SURVIVAL (BRICS) PROJECT
WORLD VISION
USAID COOPERATIVE AGREEMENT # FAO-00-98-00041-00
TERMS OF REFERENCE FOR THE THIRD ANNUAL REVIEW

Key Objective: To conduct a third annual program activity review of the Ballia Rural Integrated Child Survival (BRICS) Project" and make recommendations on future child survival activities and capacity building needs in Ballia

The Purpose of the Review

The purpose of the Third Annual Review is to identify what is working well, determine the adequacy of responses to the Mid Term evaluation recommendations, identify areas that need improvement, and recommend useful actions to guide the staff through the last year of the project. The review should recognize the achievement of the project and staff, assess progress toward sustainable high quality implementation and monitoring of child survival activities, identify barriers to achievement of goals and objectives, and recommend strategies for future extension and expansion of the project

Specific Objectives:

1. To review the accomplishments and constraints of the project from the start to the end of the third year comparing the actual accomplishment with the set goals and objectives, results, and/or outputs established in the Detailed Implementation Plan (DIP) for the period.
2. To identify factors which have contributed to the achievement of the progress and factors that have impeded progress and make recommendations.
3. To identify any substantial changes required from the approved agreement and DIP which would require a modification to the cooperative agreement and recommend if any are found.
4. To review the Mid-term evaluation recommendations and identify how the project is addressing each recommendation of the mid-term evaluation and document any other actions taken as a result of the evaluation.
5. Communicate key review findings, conclusions and recommendations of the review to clients, and document them in the form of a Third Annual Review Report, which should include but is not limited to the following:

- Summary and Recommendation including review methods, site visited, dates of field work
- Project Background
- Quality of Programming
- Quality at the community level
- Quality of Health Worker and Facility Services
- Capacity Building and Sustainability
- Technical and Administrative Support
- Main accomplishments and constraints
- Issues identified by Mid Term Evaluation and addressed by project
- Recommendation

6. To make over-all recommendations for the strategy for the continuation of the project activities beyond FY 2002.

Evaluation Methodology

The Terms of Reference proposes a review strategy that fulfills the criteria established by the USAID Child Survival Annual Review/Third Annual Review Guidelines. The review methodology will include the following.

Review Team Leader: The team leader will facilitate the review activities in a participatory manner and ensure that the review process is conducted according to USAID standards.

Data Collection and Analysis: The review team leader will be responsible for overall methodology and design of the data collection techniques, facilitating the analysis of the data, and providing an assessment of the quality of project implementation based on this data. The data collection technique may include:

- Analysis and interpretation of the results of a standard LQAS or 30 cluster knowledge, practice and coverage (KPC) third annual survey mothers with children under 23 months of age;
- An internal review based on data generated by the Health and Management Information System
- Field visits/observation
- Focus group discussion; and key informant interviews with stakeholders
- Review of project documents
- Others as required by the review team

Proposed Review Schedule

October 2 : Meeting with the entire team, review reports, develop tools, share expectations and desired outcomes/accomplishment, complaints and constraints and develop a review strategy with the team.

October 3&4: Field visits - Health Centers, community and partner NGOs.

October 5: Review of records and files, staff interviews. Principal findings and recommendations.
Debriefing of staff

October 6: Brief report of findings to local stakeholders and WV.

Team Composition

Review Team Leader: To be decided

Coordinators: Ms. Sushma Cornelius, Operations Manager,

World Vision India
Mr. Subodh Kumar, M&E Officer, World Vision India
K.A. Jayakumar, Team Leader, BRICS and Ballia ADP
Dr. Beulah J Kumar, BRICS Project Manager

Team members: Chief Medical Officer, Ballia district

MOICs from PHCs in Ballia
SMO- WHO Ballia District
Various stakeholders from Ballia/U.P
Dr. Ivan Wold Vision Mayanmar
Manju World Vision North Zone
Bradely Monitoring Evaluation Dept. National Office, Chennai
Sushmita - Monitoring Evaluation Dept. National Office
S.Jayakumar- Manager ADP Aparajita

Expected Outcome

The external review consultant, will be responsible for preparing the final report which must meet all the requirements outlined in the Third Annual Review guideline. A draft review report will be completed and presented at the conclusion of the review visit. Following the visit, the consultant will edit and refine the draft document into final form. It will be the responsibility of the consultant to forward the final draft to the country office (Mr. John Mathai) , the regional office (Dr. Sri Chander) and the WVUS office. (Fe Garcia/ Chris Herink)) for approval and comments. It is essential that the Third Annual Review Report is received by all offices no later than November 30, 2001

Appendix VII **Mapping of the partners in the District**

S. No	Name of Block	# of Villages	Total Population	# of families	Literacy rate	Partner in CS network	Program replicated	Planned Program	Proposed Date
1.	SIYAR	157	163507	22689	61.1	Pratinidhi Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
2.	NAGRA	168	198538	26970	60.0	Pratinidhi Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
3.	RASRA	150	126727	17838	58.4	Purvanchal Gramin Chetna Samiti	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages	By Sept 2001

								Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	
4.	CHILKAHAR	132	126841	17480	59.9	ADP Ballia	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
5.	NAVANAGAR	93	109342	15698	62.3	Pratinidhi Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
6.	PANDAH	80	103501	14382	56.2	ADP Ballia	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc.	By Sept 2001

								SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	
7.	MANIAR	109	98803	13755	52.7	Subhash Memorial and Manav Chetna Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
8.	BERU ARBARI	83	150686	11801	58.8	ADP Ballia	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
9.	BANSDIH	150	104633	14940	51.5	ADP Ballia	KPC Survey PLA Component	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and	By Sept 2001

							s of CS	Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	
10.	REVATI	102	101860	13890	51.3	Naval Shikshan Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
11.	GARWAR	151	116038	15975	65.6	Soalnki Grameen Gramodhyog Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
12.	SOHANV	109	113921	15641	57.0		KPC Survey PLA	Community Convergent Action Panchayats trained on RCH,	By Sept 2001

							Components of CS	Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	
13.	HANUMANGANJ	89	132865	17784	61.8	Soalnki Grameen Gramodhyog Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
14.	DUBAR	102	126572	17425	63.2	Naval Shikshan Sansthan	KPC Survey PLA Components of CS	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
1	BELHA	45	92865	1346	62.3	Naval	--	Community Convergent Action	By Sept

5.	RI			6		Shikshan Sansthan		Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	2001
16.	BAIRIYA	45	128167	18065	62.7	Soalnki Grameen Gramodhyog Sansthan	--	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001
17.	MORLI CHAPRA	25	107342	15088	61.3	Soalnki Grameen Gramodhyog Sansthan	--	Community Convergent Action Panchayats trained on RCH, Panchayati Raj, Monitoring and Evaluation of Govt. Programs etc. SHG formation and credit linkages Reproductive and Child Health Activities Replication of Pregnancy, Immunization and Family planning record maintenance	By Sept 2001

Appendix VIII Development Presentation

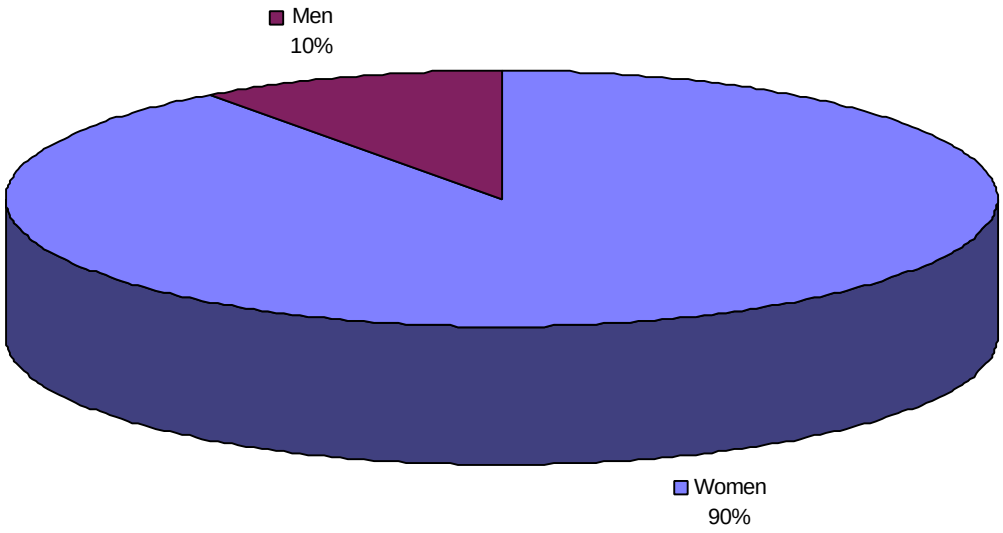
Development Activities

MED

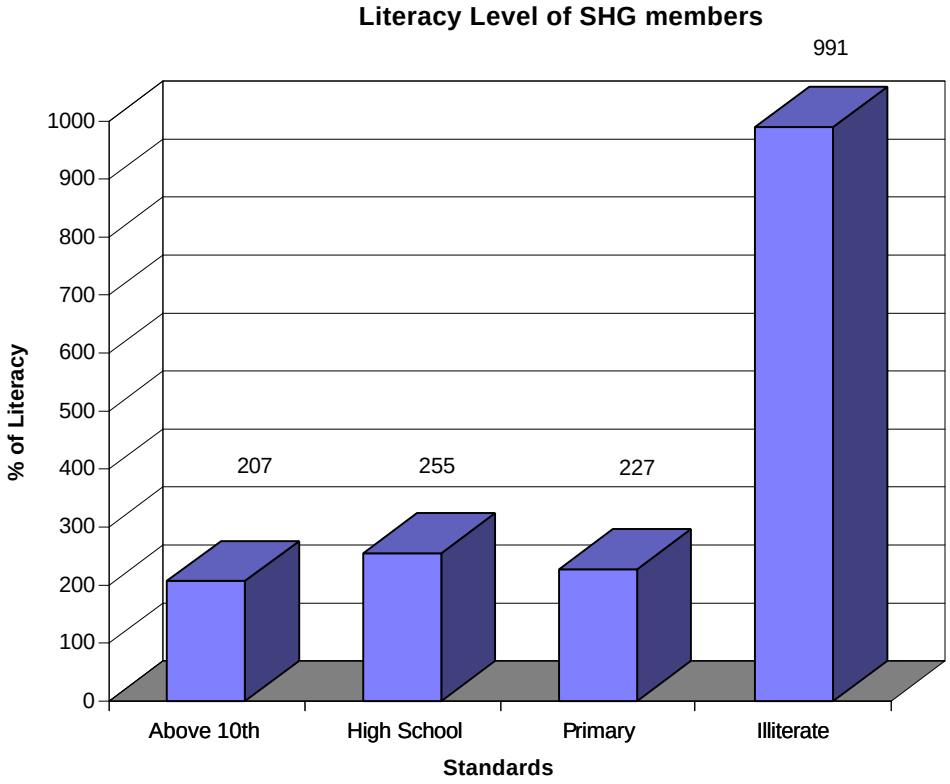
- **To enable community (especially women) in making best use of their existing as well as potentially accissible economic resources inorder to make them selfreliant.**

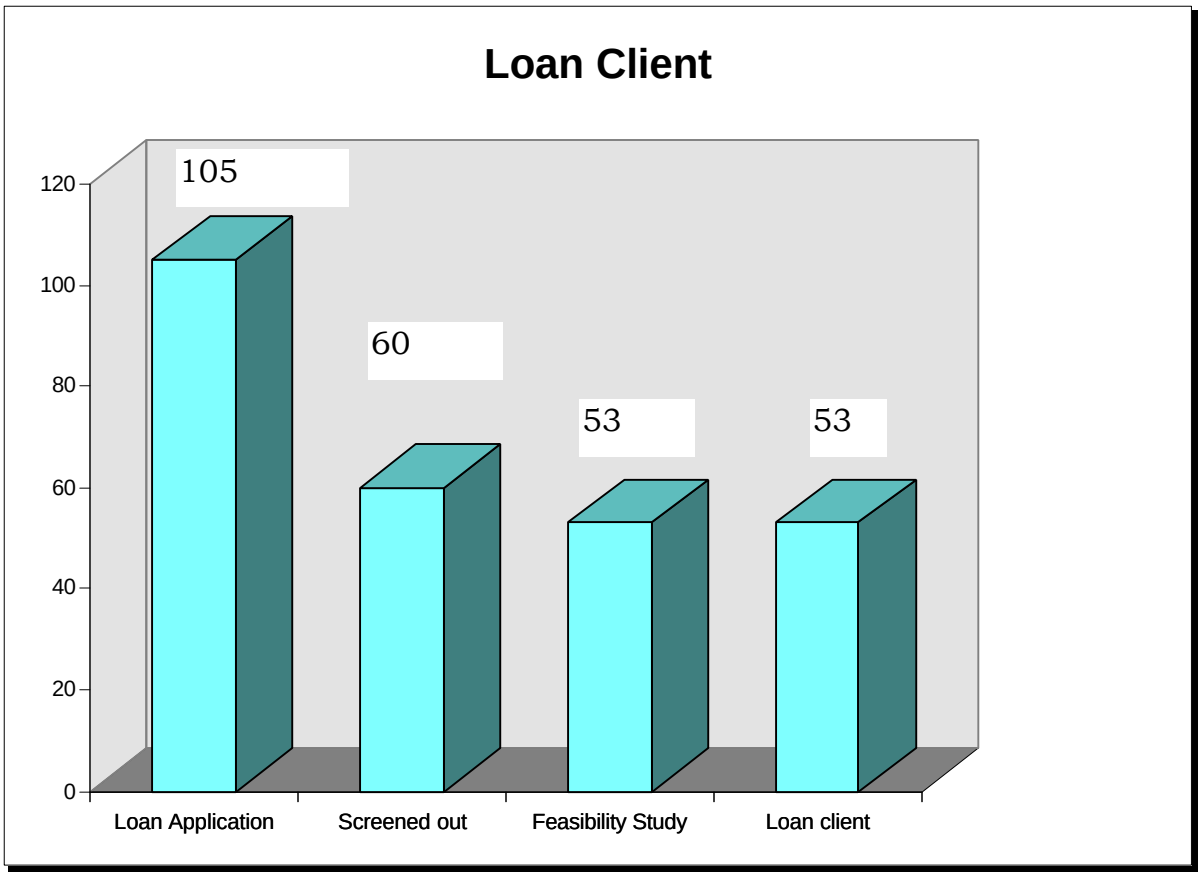
- **Women's Empowerment**

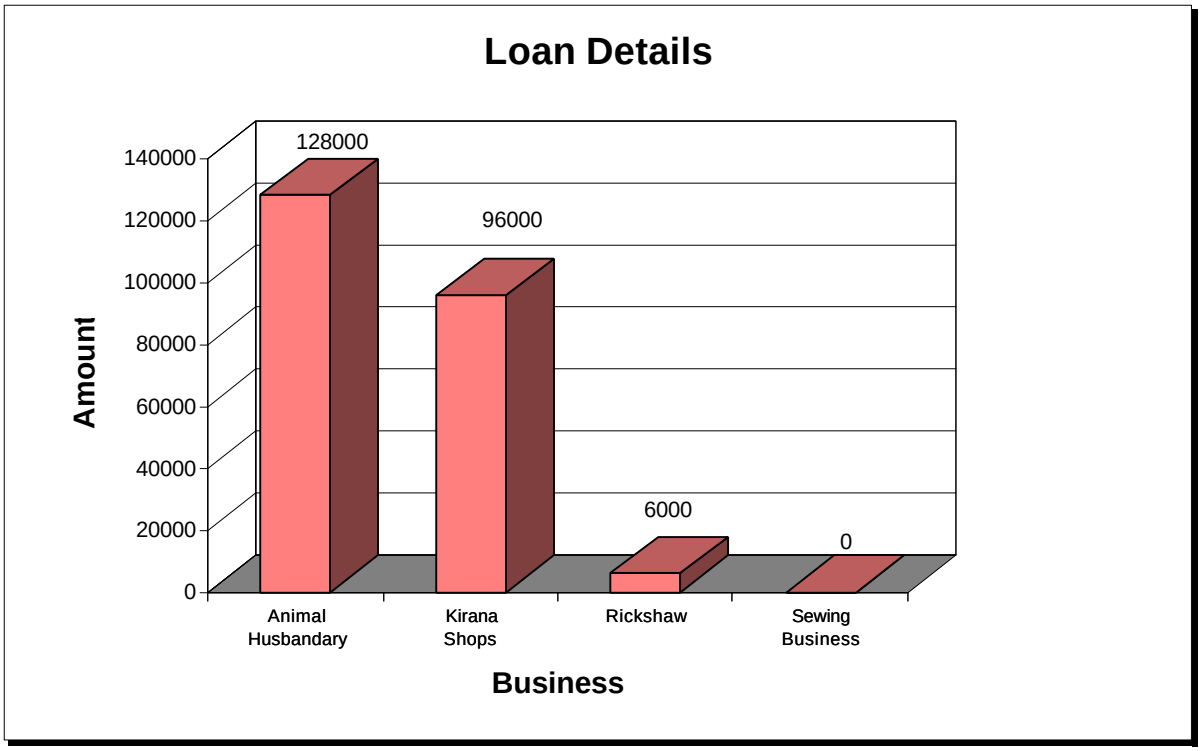
Involvement of Men & Women in SHGs



Total Number of SHGs	**: 159**
Women Groups	: 143
Men Groups	: 16
Minimum Members in a group	: 12-15


Literacy Level of SHG members
991
1000
900
800
700
600
500
400
300
200
100
0
% of Literacy
207
255
227
Above 10th
High School
Primary
Illiterate
Standards

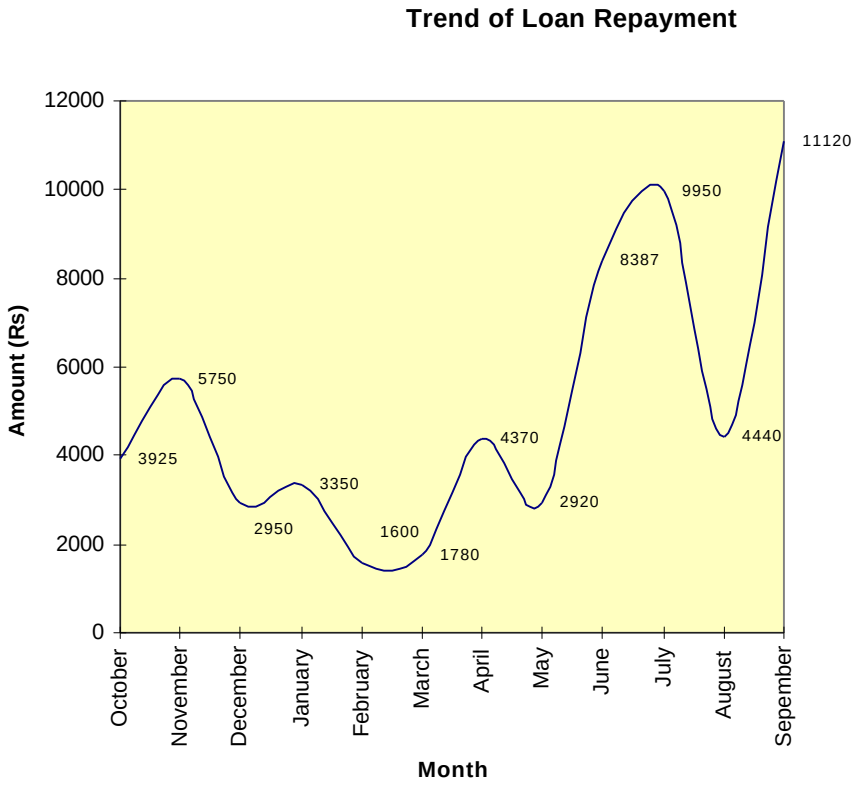

Loan Client
120
100
80
60
40
20
0
105
60
53
53
Loan Application
Screened out
Feasibility Study
Loan client

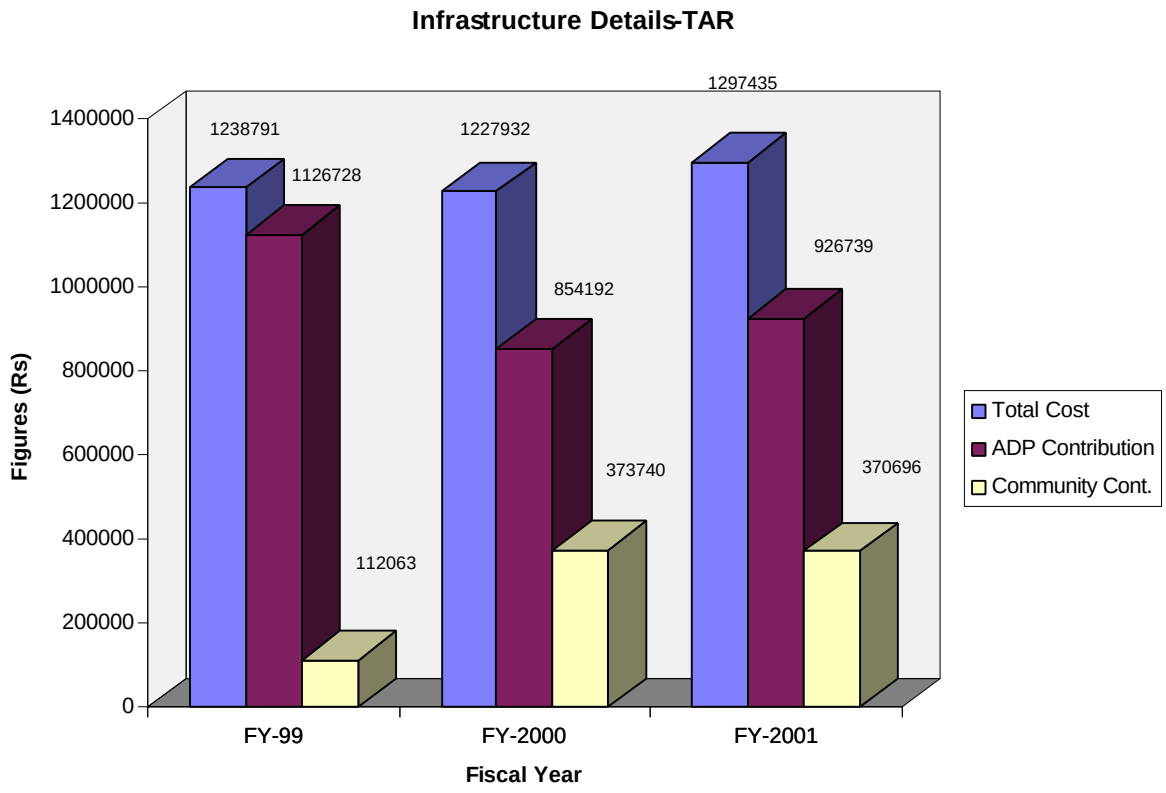


FY-2001 : Amount of loan disbursed : Rs. 230000.00

FY-2000 : Amount of loan disbursed : Rs. 177000.00

Total amount of loan disbursed : Rs. 407000.00


Trend of Loan Repayment
12000
10000
8000
6000
4000
2000
0
Amount (Rs)
3925
5750
2950
3350
1600
1780
4370
2920
8387
9950
4440
11120
October
November
December
January
February
March
April
May
June
July
August
Sepember
Month



Infrastructure Details includes: FY-99

(A) 2 Untarred roads: Narayanpur, Harpur
(B) 2 Drains: Rajpur, Kaitholi
(C) 2 Soakpits: Narayanpur, Karampur
(D) 21Handpumps: Narayanpur(1), Mairitar(7), Kaitholi(5), Durgipur(2), Karampur(4), Bhojpur(1), Harpur (1)
(E) 1 Sabha Bhawan: Shahudih

Infrastructure Details includes: FY-2000

(A) 5 Untarred roads: Shivrampur, Badsari, Aschauraha, Kaitholi, Mairitar
(B) 4 Drains: Shivrampur, Badsari, Rajpur, Mairitar

Infrastructure Details includes: FY-2001

(A) 6 Untarred Roads: Gangbhev, Mohoi, Shivrampatti, Karammar, Jamalpur, Kumiahara, Shivrampur
(B) 3 Drains: Tandawa, Shivrampur, Mohoi

ANTICIPATED IMPACT OF ROAD & DRAINAGE CONSTRUCTION

Through construction of road community people will have;

1. positive impact on their socio economic conditions.

2. better and rapid access to local markets to avail basic amenities and business.

3. easy access to the medical facilities during emergencies.

4. help in obstetric emergency transport system.

5. Decrease in school dropout during rainy season.

6. ANMs/ PHC staff will able to make regular visits for immunization and during time of any epidemic outbreak.

7. Reduction in water borne diseases like diarrhea, skin infections etc.

8. Better sanitation & hygienic conditions with less water clogging

Appendix IX KPC 2001 Report

Chief Medical Office, Ballia
United States Agency for International Development
World Vision

Report on

Year III Knowledge, Practice and Coverage (KPC) Survey

of the
Direct Impact Area (Beruarbari block)
Ballia Rural Integrated Child Survival Project
Implemented by :
Ballia Area Development Program
World Vision India
Uttar Pradesh, India

26 September 2001

Beginning Date : October 1, 1998
Ending Date : September 30, 2002

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ACKNOWLEDGEMENTS

The Project records its deep appreciation of the support and guidance of the Chief Medical Officer of Ballia, Dr. O.P.Singh in conducting this survey.

Thanks are also due to the Medical Officers of the Primary Health Center, Beruarbari who recruited staff of the PHC to serve as supervisors in the survey.

We record with gratitude the cooperation given by the Pradhans, members of the local government, in all the villages where interviews took place.

Many thanks to World Vision senior management for moral support and encouragement.

Technical support received from Dr. Sri Chander, WV APRO and Subodh Kumar, Monitoring and Evaluation Officer of World Vision India, North Zone is deeply appreciated.

We thank all the Survey Staff who, despite being drawn from wide ranging areas of work, showed much enthusiasm and willingness to work hand in hand, to make this a reality. Annex i gives a listing of the staff.

We also thank all the supervisors, interviewers and gatekeepers; their names appear in annex iv of this report.

Staff of the Project and local students came forward to feed data after working hours. The Project is grateful for their timely help.

Above all, are grateful to the mothers of children and other members of their families who readily came forward to give the interviews.

TABLE OF CONTENTS

LIST OF ACRONYMS

ADP	Area Development Program
ANM	Auxiliary Nurse Midwife
APRO	Asia Pacific Regional Office
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCG	Bacillus Calmette Guerin
CDO	Community Development Organizer
CMO	Chief Medical Officer
CSP	Child Survival Project
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded Program on Immunization
GOI	Government of India
GSS	Gramin Swasthya Sevika (Hindi for Community Health Worker)
KPC	Knowledge, Practice, Coverage
LCO	Lady Community Organizer
LQAS	Lot Quality Assurance Survey
ICDS	Integrated Child Development Scheme
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTE	Mid Term Evaluation
NFHS	National and Family Health Survey
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
PHC	Primary Health Center
PVO	Private Voluntary Organization
TOT	Training of Trainers
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision

EXECUTIVE SUMMARY

The Ballia Rural Integrated Child Survival (BRICS) Project completed its third year of implementation and this Knowledge, Practice and Coverage (KPC) survey was conducted in the Project's direct impact area (Beruarbari block - 82 villages, population 152, 000) in September 2001 to assess progress toward objectives.

Though the Project is currently operational in all the 17 blocks of the district, Beruarbari continues to be its 'demonstration site'. This is the fourth KPC survey being conducted in this block.

This survey method employed was the WHO 2 stage 30 cluster sampling methodology. This year's survey has some additional, unique features :

- Parallel sampling was employed - and 2 different questionnaires were used, one for each sub sample.
- Immunization and vitamin A supplementation were recorded based on mothers' recall along with card documented ones.

Local stakeholders were involved in most stages of the survey, to make it truly client centered.

In the following areas, the Project has **both crossed the benchmarks for the year as well as the previous year's performance :**

- Full immunization coverage of children aged 11 to 23 months of age has increased from 66.1% last year to 74.3% . Measles coverage has increased by 6.3% over the past year and DPT I - III dropout rate has come down to 11.4.
- TT2 coverage in pregnancy is 85.9% as against last year's
- Exclusive breastfeeding upto 4 months of age (92.7%)
- Appropriate complementary feeding of children 6 to 23 months of age (79.9%)
- Consumption of IFA tablets in pregnancy (32%)
- Knowledge of mothers regarding signs of illness in children that would prompt care seeking (87.5%)
- Spacing between children (at least 2 years) - only 10% mothers with a child less than 24 months are pregnant now.
- Use of contraception by those who do not desire any more children or are not sure (23.4%).

In the following area, the Project has **exceeded last year's performance, but has not reached the benchmark for this year :**

- Vitamin A supplementation in children aged 11 to 23 months of age - 74.9%, against the benchmark of 85%.

In the following **there has been change in protocol/policy, and acceptance has only begun :**

- Exclusive breastfeeding upto 6 months (as opposed to 4 months)
- Consumption of at least 100 IFA tablets (as opposed to 90 tablets) in pregnancy.

In the light of the above findings in the KPC survey of Year 3 of the Project, the management is led to conclude that expansion of Project activities from Beruarbari block to the other 16 blocks of the district and shift in roles between the CDO/LCO and the GSS (both recommendations of the MTE) has not affected program results in the direct impact area.

BACKGROUND

PROJECT LOCATION & DEMOGRAPHY

The Ballia Child Survival Project is located in the remote and underserved Ballia district in the eastern part of Uttar Pradesh state, 20 km from the border with Bihar state. Ballia is 4 hours' drive from Varanasi, the nearest airport.

The total population of the district is 2.5 million and it is divided into 17 administrative units called 'blocks'. Eighty percent of the population is rural and the population density averages 1,934 people per sqkm. The sex ratio is 946 females for every 1,000 males. Only 23.7% of women are literate and the median age at marriage for girls is 16 years. About 79% of the population belongs to "low" castes (scheduled and other backward castes) most of whom are landless laborers. The economy is predominantly agrarian. Seasonal unemployment is widespread, leading to high seasonal migration to other states. Household incomes average $20 - 30 a month which is well below the GOI stipulated poverty level of $33 (Rs. 1,200) a month.

U.P. is still home to very high infant and maternal mortality rates (99.9/1,000 live births and 570/100,000 live births respectively) despite reductions being achieved in these rates in other states of the country.

PROJECT OVERVIEW

The BRICS Project is nested within the 20 - year Ballia Area Development Program (ADP). The ADP is World Vision's core programming unit worldwide, having different sectoral activities integrated into a single geographic unit, (which, in the case of India, is the block) and planning to subsequently radiate into more such units.

Ballia ADP began in November 1996 and its areas of emphasis include health, income generation, infrastructure development, early childhood care and development and local leadership development, the plan of activities being jointly developed with the community and has objectively verifiable results and a plan for sustainability. Most of the funding for ADP activities is drawn from child sponsorship and at present there are 1,376 sponsored children in ADP Ballia.

BRICS, funded through a cooperative agreement of World Vision with USAID, was initiated in October 1998, in collaboration with the GOI and the Ballia CMO.

The direct impact area of BRICS is Beruarbari, the largest block of Ballia district, with a population of 150,121 residing in 82 villages. BRICS has been working in this block in a phased manner, all the 82 villages being covered from the third year. Three KPC surveys have been done in this direct impact area , in 1998 (baseline), 1999 (for the First Annual Review), and 2000 (for the Mid Term Evaluation).

Though BRICS is now operational in all the 17 blocks of the district, Beruarbari continues to be the Project's "demonstration site" or direct impact area.

BRICS - GOALS AND OBJECTIVES

The Project's strategic objective is to *assist the Ballia district CMO, private sector and community partners to accomplish, sustain, document and replicate best practices to reduce fertility, infant, child and maternal mortality through an innovative child survival and reproductive health project in Beruarbari block of Ballia district over a four year period.*

The project plans to go to scale by replicating best practices in child survival and reproductive health to (a) the entire Ballia district (all the 17 blocks) and (b)four other World Vision ADPs in U.P.

MODEL OF WORK

BRICS does not provide direct services, but rather acts in the following ways -

- *mobilizing* - a cadre of village based health workers called Gramin Swasthya Sevikas (GSS) who are trained on the technical aspects of the intervention areas as well as in BCC and counseling skills (576 GSS have been trained in the district)
- *capacity building* - of the GSS and local stakeholders viz., MOH staff, community leaders and partner NGOs;
- *linking* - beneficiaries with care providers, through the GSS and community leaders;
- *planning* - for increased coverage;
- *advocacy and support* - for increased supply and quality.

AREAS OF INTERVENTION - TECHNICAL (in direct impact area)

1. Increased immunization coverage
2. Improved care during pregnancy and delivery
3. Increased coverage of birth spacing/family planning services
4. Prevention of malnutrition and vitamin A deficiency
5. Essential care of the sick child (IMCI)
6. Essential care of the newborn

EXPANSION OF ACTIVITIES

The recommendation of the MTE served as a springboard for the Project to mainstream its activities to the other 16 blocks of the district. In 2 of these blocks, the Project is pilot testing 2 different models of expansion and in the other 14, implementation is done through the Project's 6 NGO partners.

This survey is also intended to assess the effect, if any, that the expansion might have had on the direct impact area (see below).

OBJECTIVES OF THE SURVEYS

The objectives of this survey was to assess progress of the project towards objectives - the extent to which the benchmarks set for the current year have been attained :

1. *knowledge* of mothers with children less than 24 months of age about major threats to child health.
2. Reported *practices* of these mothers with regard to breastfeeding, infant nutrition, home deliveries, birth spacing methods and care of the newborn.
3. *Coverage* rates of immunization of children under 23 months of age and of pregnant women as per the National Immunization Schedule and the dropout rate; birth spacing methods; vitamin A coverage in children.
4. Impact, if any of the expansion (of Project activities into the district) on program results in the direct impact area.

PARTNERSHIP BUILDING

The Project believes that successful partnerships are the means to program sustainability. Local stakeholders were involved in every stage of the survey, especially in the data collection process :

- Staff of the PHC served as supervisors
- Members of Self Help Groups and Community Action Groups of Beruarbari and GSS of the block were involved as interviewers and gatekeepers.
- Staff of the partner NGOs were involved as survey staff.

Plan for debriefing :

Results of the survey will be presented to all local stakeholders of the Project viz, Panchayat members, SHG members, MOH staff and Project grassroots workers.

METHODS

This survey was based on the WHO 30 cluster sampling methodology. **Parallel sampling** (see below) was employed in this survey, based on the guidelines in the Field Guide KPC 2000+ from the PVO Child Survival Support Program.

The surveys were done with full cooperation of the district Chief Medical Office, PHC Beruarbari, NGO partners and community leaders.

SAMPLING DESIGN

The type of design of the survey was the two stage cluster sampling based on the WHO standard 30 cluster sampling methodology.

Parallel Sampling

For reasons mentioned below, the sample was divided into 2 sections, viz, mothers with children aged 0 - 11 months and those with children aged 12 - 23 months. 300 mothers from each group were interviewed, making the total sample size 600.

Parallel sampling was used for the following reasons :
1. To increase the size of subsamples
2. To reduce “recall” bias
3. To reduce the time taken for each interview

2 questionnaires were prepared, one for each group (please see subtitle Questionnaire for further details).

Sample Size Calculations / Randomization

- The census data of the 2000 General Elections was the basis for creating the sampling frame.
- The first cluster was chosen randomly using numbers from currency notes.
- Subsequent clusters were chosen by adding the sampling interval to the random number.
- Sampling Interval = Cumulative Population/30
- In each of the 30 clusters, 20 households were selected, 10 with mothers of children 0 -11 months of age and 10 with those of children 12 - 23 months of age, resulting in a sample size of 600.

Selection of the households and interview protocols

- Within each cluster, the number and names of tolas (hamlets) were noted and one was randomly chosen by the supervisor. This was followed by random selection of direction by spinning a pen. In the chosen direction within the tola, the first household was chosen again randomly. After random selection of the first household, subsequent households were taken up for interviews in the same direction until 20 interviews were completed. These steps ensured that all households in the cluster had equal chances of being selected irrespective of the tola they fall in.

- Not more than one interview was done in any household, in order to avoid the bias that might arise out of commonality in practices among women of the same household.

- If the team encountered more than 2 children less than 24 months in any household, the younger of the two was chosen for the interview. If there were more than one mother with a child less than 24 months, one of them was chosen randomly.

- Supervisors in each team also filled out a Supervisors Form at the end of each day of survey, which has details of the household selection process as well as difficulties and problems encountered by the team.

QUESTIONNAIRE

The surveys were conducted using customized forms of the generic KPC survey questionnaire developed by the Johns Hopkins University School of Public Health, PVO Child Survival Support Program (KPC 2000+ Field Guide).

As parallel sampling was used, 2 different questionnaires were made, one for mothers of children 0 - 11 months of age (with questions on antenatal care and delivery) and another for those with children 12 - 23 months of age (with questions on immunization). Inputs from the Technical Advisors from the Zonal and Regional Offices were sought on the drafts.

Other changes were made to the questionnaire used in the previous KPCs of the Project, keeping in mind the principles outlined in the Field Guide -

- whether the information is "nice to know or need to know"
- how the information will influence program design and management
- whether the same information can be obtained from another source/survey.

Questions on knowledge of mothers were kept to a minimum as it has been the project's experience that women are rarely forthcoming with regard to questions on danger signs - speaking about them is considered inauspicious. Much probing skill and open - ended questions are needed to assess the knowledge of these mothers which can be better accomplished through qualitative studies.

Questions on antenatal care have been deleted as only one component of antenatal care, viz. dispensing of iron/folate tablets is being done in the subcenters. (This issue is being taken up with the CMO and action is yet to be taken). Questions on iron/folate intake and those on TT immunization have been retained.

In the immunization section, history based recording has been introduced, in addition to card documented immunizations. This has been done in response to widespread opinion of staff of all PHCs of the district (during debriefing of baseline KPC findings in other blocks) that keeping cards safe is not a priority in rural areas.

But it was decided that only those immunizations that the mother is able to name clearly would be recorded ; protocol regarding site of vaccination is not strictly being followed and hence the name of the vaccine given cannot be deduced from the site of injection.

Each interview took approximately 15 minutes to complete.

The questionnaires were written in English and translated to Hindi, the regional language. The Project staff and local language helpers did the translation into the local dialect, Bhojpuri. Back translation into Hindi and then into English was then done to verify accuracy of translation . Further revisions were done after practice sessions and field tests.

SCOPE OF THE SURVEYS

The following areas were covered :

1. Breastfeeding and Infant Nutrition
2. Vitamin A deficiency
3. Immunization
4. Care during Pregnancy and Delivery
5. Birth Spacing/Family Planning

As birth registration is not commonly done in Ballia, mothers usually do not remember the birth dates of their children. To circumvent this problem, the survey teams used an Events Calendar, developed by the Project during an earlier KPC survey. The mothers are asked to relate the festival around which time the child was born. This helps deduce the birth date of the child with a fair amount of accuracy.

STUDY INDICATORS

The following indicators can be gleaned from the surveys :

BREASTFEEDING & COMPLEMENTARY FEEDING

- % children 0 - 6 months of age who were exclusively breastfed in the last 24 hours.
- % children 6 - 23 months of age who were given complementary foods along with breast milk in the last 24 hours.

VITAMIN A DEFICIENCY

- % mothers who reported current night blindness.
- % mothers who reported night blindness during their previous pregnancy.
- % children 11 - 23 months of age who were given a dose of vitamin A concentrate in the past 6 months(card documented and recall based)
-

IMMUNIZATION

- % children 11 - 23 months of age who are fully immunized (card documented and recall based)
- Coverage rates for BCG, OPV3, DPT3 and Measles.
- % mothers who had received TT2 in their previous pregnancy (card documented and recall based)

CARE DURING PREGNANCY & DELIVERY

- % mothers who had consumed at least 100 (90) iron/folic acid tablets during their previous pregnancy (card documented)
- %deliveries that were attended by a trained provider.

BIRTH SPACING/FAMILY PLANNING

- % mothers (with a child less than 24 months of age) who are pregnant now.
- % mothers who do not want another child in the next 2 years, or are not sure, who are using a modern contraceptive method.
- Contraceptive use by type.

TRAINING/DATA COLLECTION & ANALYSIS

See annex iii for the schedule of training , data collection and analysis.

SURVEY STAFF

Each team consisted of four members - one supervisor, two interviewers and one gatekeeper.

15 teams were formed and each team was responsible for completing interviews in 2 clusters, over a period of 2 ½ days. Time was also given for them on the last day of data collection to go back and fill up any incomplete part in any interview.

One interviewer interviewed the mothers of children 0 - 11 months of age and the other interviewer covered the mothers of children 12 - 23 months of age. This was done to avoid confusion among the staff and wrong questionnaires being administered.

The supervisors were women & men, literate, with some experience in health work and in supervision. They did the household selection, monitored interviews, audited completed interview forms and were responsible for all the interviews assigned to their team until the completed forms were handed over to and checked by the Survey Coordination team.

The interviewers were women, literate and fluent in the local language.

The gatekeepers were men who were appointed to look out for potential unrest and disturbances during the time of the interviews and to help ward them off.

All the survey staff were residents of Beruarbari and the training was mandatory for all of them.

Data feeding, cleaning was done by the project staff, under the supervision and assistance of the coordination team. Analysis was done by the coordination team.

EPI Info version 1.6 and MS Excel packages were used for analysis and calculations.

QUALITY ASSURANCE & CAPACITY BUILDING

Training of survey staff was done primarily by the CSP Manager, but many parts were handled by other members of the coordinating team.

The team members also did rounds of the selected clusters during data collection, to ensure adherence to randomization techniques and to backstop and encourage.

The coordinating team looked after the overall smooth conduction of the training data feeding as well as to ensure quality in all the above steps. Annex I details the members of the core team.

Care was taken to avoid recruit the same field staff who were present in the ’00 survey, so that a maximum number of people might benefit out of this capacity building exercise.

Those project staff who had not been involved in data feeding in the preceding surveys were trained and used this time, under supervision.

RESULTS

The following indicators were derived from the analysis tables of EPI Info version 6.4 and from MS Excel (see annex v for the raw data). Confidence intervals were calculated by hand for some of the indicators, assuming a design effect of 2.

Indicator	Numerator	Denominator	Percentage	Confidence Limits
Breastfeeding/Infant Nutrition				
1. %children 0 - 6 months of age who were exclusively breastfed in the last 24 hours	164	191	85.9	80.1 - 90.5
2. %children 0 -4 months of age who were exclusively breastfed in the last 24 hours	139	150	92.7	90.5 - 94.9
3. %children 6 - 23 months of age who were given appropriate complementary food along with breastmilk in the last 24 hours.	343	429	79.9	78.9 - 81.2
Vitamin A				
4. % mothers who reported night blindness during their previous pregnancy.	47	299	15.7	
5. %mothers who reported current night blindness.	62	600	10.3	15.1 - 16.3
6. %children 6 - 23 months of age who were given a dose of vitamin A in the past 6 months. (card documented)	125	167	74.9	9.9 - 10.7
Immunization				
7. %children 11 - 23 months of age who are fully immunized - card documented	124	167	74.3	73.0 - 76.8

and recall based	97	300	32.3	
8. Coverage rates for BCG, OPV3, DPT3 and Measles :				72.6 - 76
BCG	154	167	92.2	
DPT I	153	167	91.6	31.5 - 33.1
DPT II	145	167	86.8	
DPT III	132	167	79.0	90.2 - 94.2
OPV I	149	167	89.2	
OPV II	138	167	82.6	89.6 - 93.6
OPV III	129	167	77.2	84.9 - 88.7
Measles	124	167	74.3	
7. % mothers who received TT2 during their previous pregnancy - card documented	110	128	85.9	77.1 - 80.9
and based on recall.	213	300	78.3	88.3 - 90.1
Care during pregnancy & delivery				80.7 - 84.5
8. % mothers who consumed at least 90 IFA tablets during previous pregnancy.	96	300	32	75.5 - 78.9
9. % mothers who consumed at least 100 IFA tablets during previous pregnancy.	69	300	23	72.6 - 76 84 - 86.8
10. % deliveries attended by trained providers.	65	300	22	76.6 - 79
Care of the Sick Child				
11. %mothers of children 0 - 23 months who knew at least 2 signs of illness in children that would necessitate treatment.	525	600	87.5	31.2 - 32.8
Birth Spacing/Family				

Planning				
12. % mothers with a child less than 24 months who are pregnant now.	60	600	10.0	22.3 - 23.7
13. % mothers who do not want another child in the next 2 years, or are not sure, who are using a modern contraceptive method.	97	413	23.4	21.7 - 22.3
14. % usage of contraceptives				
Condom				86.5 - 88.5
OC Pills				
IUD	61	108	46.5	
Male sterilization	19	108	17.6	
Female sterilization.	1	108	0.9	
	1	108	0.9	9.6 - 10.4
	23	108	21.3	
				22.7 - 24.1
				44.9 - 47.1
				16.8 - 18.4

				20.2 - 24.3

DISCUSSION

Following is a discussion of the results of the survey, comparisons have been attempted with the Project's benchmarks and previous years' results as well as with the MOH statistics for U.P. state.

AGE & SEX

As two parallel samples were taken (one for the age group 0 -11 months and another for 12 - 23 months), the sample size is the same for the two groups.

Within the first group, 63.7% are in the age group 0 - 6 months and 36.3% are 6 - 11 months of age. This reflects the IMR of the project area, which is 99 per 1000 live births as on NFHS and UNICEF 1997.

Gender breakdown of the children is also a reflection of the status accorded to the girl child in the area. (44.2% of the children are girls). This trend is common throughout U.P. and there has not been any significant change since 1998, when the Project began. This indicates that special initiatives are needed to close the gender gap.

Child bearing age of women shows some changes since MTE - almost 80% of mothers fall in the age bracket 20 to 30 years. Another encouraging finding is that the high risk behavior of bearing children before 18 years of age has remained at 2%.

BREASTFEEDING/INFANT NUTRITION

92.7% children aged 0 - 4 months have been reported to be exclusively breastfed (confidence limits 90.5% to 94.9%). This is higher than this year's benchmark of 85% and last year's figure of 91%.

However, the message of exclusive breastfeeding upto 6 months of age has only begun to be accepted and practiced, the figure for which is 85.9% (confidence limits 80.1% to 90.5%). This is fairly high considering the fact that this message is being conveyed only since January and the MOH protocol is to "exclusively breastfeed upto 4 to 6 months". The line diagram in annex vi for Trends in Exclusive Breastfeeding shows a sharp decline in this behavior from 4 months of age onwards. Further research into this behavior and a sustained BCC effort are needed.

A surprisingly high 79.9% (confidence limits 78.9% to 81.2%) children aged 6 to 23 months were fed at least 2 appropriate complementary foods. This is much higher than the benchmark set for this year. However, this survey does not answer questions like the amount and frequency of complementary feeding and the cooking methods used, which will only be answered by qualitative studies.

42.7% mothers reported to have weaned their children between 6 to 9 months and 27.1% at about 6 months. Late weaning is still a matter of concern and this highlights the need for education and behavior change among women in the community.

IMMUNIZATION

At the behest of all levels of MOH staff, immunization based on history was also recorded this time, along with that documented in cards. It was decided that only those immunizations that the mother is able to name clearly would be recorded ; protocol regarding site of vaccination is not strictly being followed and hence the name of the vaccine given cannot be deduced from the site of injection.

The findings reveal that card based immunization coverage is higher than the coverage based on recall.

Full immunization of children is an encouraging 74.3% . We are 95% confident that the coverage is between 72.6% and 76%. There has been an increase since MTE when the coverage was 66.1%.

Individual coverages have also improved, with measles coverage showing an increase of 6.3% over the past year.

DPT I - III dropout rate has declined. Current dropout rate is 11.4%, while the finding of the last survey was 16.6%.

TT2 immunization of mothers during previous pregnancy has also increased from last year's figure of 76.7% to 85.9% (confidence limits 84% to 86.8%). This increase is way higher than the Year 3 benchmark of 25%. Coverage figures obtained based on recall is also higher than previous figures (78.9%).

VITAMIN A

Card documented coverage of vitamin A supplementation of children in the past 6 months is 74.9% (confidence limits 73% to 76.8). Though this is higher than previous year's coverage, it falls short of the Year 3 benchmark of 80%. We are 95% confident that the program objective has not been reached regarding vitamin A supplementation of children.

Mothers reporting night blindness during previous pregnancy has also gone down, interestingly. 15.7% mothers have reported this finding this year, while the figure for last year was 24.3%.

CARE DURING DELIVERY

32% mothers have reported having consumed at least 90 IFA tablets during previous pregnancy (confidence limits 31.2% to 32.8%) as against the benchmark of 25%. The finding is 3% higher than last year's figure.

As the minimum consumption of IFA tablets has been revised to 100 by UNICEF, the message was been given through BCC sessions. Though the %of mothers who reported having taken 100 or more tablets is only 23%, analysis of those 32%mothers who had consumed at least 90 tablets shows that 72% of them had taken between 90 to 100 tablets

and 3% over 100 tablets and only 25% of them had taken just 90 tablets. This shows that the message is gaining acceptance and is being practiced too. Further efforts to this end are required to bring about a reduction in pregnancy related anemia and save tomorrow's children.

Only 22% of deliveries in the past year have been attended by trained health providers. This is the same as this year's benchmark . Part of the reason could be because the program managers have refused to consider the 14.7% of deliveries conducted by "private ANM" as having been attended by a trained provider, as this cadre of care providers do not meet standard protocols during delivery and in care of the newborn. However, seeking the assistance of trained TBA has shot up from 0.7% last year to 7.3% this time around.

There is need for a change in care seeking behavior in the community and for a greater utilization of the services of the TBAs trained by the Project.

CARE OF THE SICK CHILD

87.5% of mothers were able to tell at least 2 signs of illness in children that would prompt them to seek care (confidence limits 86.5 - 88.5). This is higher than last year's figure of 64.04% and this year's benchmark of 65%.

BIRTH SPACING/FAMILY PLANNING

Only 10% of mothers with children aged 0 to 23 months were pregnant at the time of the survey (confidence interval 7.8% to 12.8%). This is marginally lower than last year's figure of 11.9% and is an encouraging finding that suggests that the combined efforts of the MOH, BRICS and private stakeholders towards birth spacing is bearing fruit.

23.4% of mothers who did not want another child in the next two years, or were not sure, were using a modern method of contraception. This is much higher than the benchmark of 15% for the year and higher than last year's achievement of 20.4%.

Among the types of contraceptives used by the above, use of condoms has risen from 52% last year to 61%, and so has the use of IUD (0 to 0.9%) and male sterilization (0 to 0.9%) and female sterilization (0 to 0.9%). The use of the pill has gone down from 25% last year to 17.6%. This could at least partly be due to the introduction of the OCP checklist by the Project to all its depot holders. Though the use has gone down, the small but significant risk of developing complications from pill usage would definitely have been reduced. Though there has been a shift in the preference of contraceptive, the overall coverage has increased and birth spacing improved, and that is encouraging indeed.

CONCLUSION

In the following areas, the Project has **both crossed the benchmarks for the year as well as the previous year's performance :**

- Full immunization coverage of children aged 11 to 23 months of age and DPT I - III dropout rate
- TT2 coverage in pregnancy
- Exclusive breastfeeding upto 4 months of age
- Appropriate complementary feeding of children 6 to 23 months of age.
- Consumption of IFA tablets in pregnancy
- Knowledge of mothers regarding signs of illness in children that would prompt care seeking.
- Spacing between children (at least 2 years)
- Use of contraception by those who do not desire any more children or are not sure

In the following area, the Project has **exceeded last year's performance, but has not reached the benchmark for this year :**

- Vitamin A supplementation in children aged 11 to 23 months of age

In the following **there has been change in protocol/policy, and acceptance has only begun :**

- Exclusive breastfeeding upto 6 months (as opposed to 4 months)
- Consumption of at least 100 IFA tablets (as opposed to 90 tablets) in pregnancy

In the light of the above findings in the KPC survey of Year 3 of the Project, the management is led to conclude that expansion of Project activities from Beruarbari block to the other 16 blocks of the district and shift in roles between the CDO/LCO and the GSS (both recommendations of the MTE) has not affected program results in the direct impact area.

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ANNEXES

ANNEX i
List of Contributors

The following staff of BRICS formed the Beruarbari 2001 Survey Coordinating Team:

1. K.A.Jayakumar, Team Leader
2. Beulah Joseph, CSP Manager
3. Anthony John, M&E Officer
4. Elwin Dayal, M&E Coordinator
5. Deepak Kumar, Beruarbari PC in charge.

The following served as supervisors in the survey :

1. Manoj Kumar, Senior CDO, ADP Aparajita
2. Sheila Singh, ANM, PHC Beruarbari
3. Chandmati, ANM, PHC Beruarbari
4. Asha Devi, ANM, PHC Beruarbari
5. Girija Pathak, ANM, PHC Beruarbari
6. Sanjay Singh, Staff of Subhas Memorial M.U.S.Sansthan, Partner NGO
7. Vinod Kumar, Staff of Solanki Gramodhyog, Partner NGO
8. Ganesh Yadav, Volunteer staff, Bansdih
9. Kamlesh Singh, Volunteer staff, Chilkahar
10. Srikkant Yadav, Volunteer staff, Chilkahar
11. Uttam Das, CDO, ADP Ballia
12. Shailender Vimal, CDO, ADP Ballia
13. Naveen Nischal, CDO, ADP Ballia
14. Anita Joshua, LCO, ADP Ballia
15. Anita Matthews, LCO, ADP Ballia
16. Vijay Shankar, SHG member

The following served as Interviewers in the survey :
(All of them are GSS of Beruarbari)
Poonam Devi, Girija Devi, Usha Pandey, Indrawti, Maya Gupta, Usha Singh, Hira Moti, Meera Singh, Usha Verma, Urmila Singh, Meena Yadav, Janki Devi, Reeta Singh, Indumati, Sunita Devi, Rajkumari Singh, Savita Ojha, Shailkumari, Chattiya Devi, Premkumari, Ramawti Verma, Shobha Devi, Vimlesh Singh, Shanti Devi, Pratibha Tiwari, Radhika Devi, Shobha Pandey, Anita Singh, Seema Verma, Vimla Devi and Tarkeshwari

The following served as gatekeepers :
(All are Youth Club members and members of the community in Beruarbari unless indicated otherwise)
Sarvajeet Kumar, Rajkishore Sahni, Ishwar Chand (partner NGO staff) Ramlal Yadav, Virender Verma, Triloki Nath, Raju Yadav, Dinesh, Vijay Peter (partner NGO staff) Kartik Prashant, Arvind Kumar, Bihari Lal, Sambunath Pandey, Arun Kumar, Uday

Shankar Pandey, Vinay Kumar, Ram Kirpal, SujeetKumar, Jagat Narayan, Ram Sanihi, Shivnath Pandey, Naveen Sahu (Project accountant) Uma Shankar, Sunil Dennis and Gupteshwar (partner NGO staff)

The following staff helped the Coordination Team in data feeding :

1. Sunita Kumari, LCO
2. Naveen Nischal, CDO
3. Stephen Cross, CDO

ANNEX ii
Training and Data feeding Schedule

Training of survey staff was held in the project sub office in Beruarbari and data feeding and analysis were held in the Project office at Ballia.
The following is the schedule for training and data collection and analysis :

13.09.01

Forenoon:	Introduction to KPC survey
	Sampling principles &randomization
	Checklist for the survey
	Role of members of the survey teams
Afternoon:	Interviewing techniques
	Explanation of questionnaires
	Formation of team and logistics

14.09.01

Forenoon:	Pretesting for the teams
Afternoon:	Data collection

15.09.01

Forenoon:	Data collection (contd)
Afternoon:	Data collection (contd) &feeding (in Project Office)

17.09.01
Data feeding (contd)

18.09.01
Cleaning of data

19.09.01
Analysis of data and preparation of draft report.

ANNEX iii
Population Data and Primary Cluster Sampling

BERUARBARI 2001 KPC

BRICS (Ballia Rural Integrated Child Survival Project)
Sampling Interval : 151804/30= 5,060
Random No: 3859 (Selected out of 385969 first four digits from left to right)

S.No	Name of Village	Population	Cumulative Population	Cluster No
1	DELUHA	1189	1189	
2	ASEGI	1215	2404	
3	SURYAPURA	3255	5659	1
4	BHIMPUR	65	5724	
5	JAGDISHPUR	825	6549	
6	GANGBEV	850	7399	
7	PINDHARA	837	8236	
8	BHABNAULI	825	9061	2
9	GANGPUR	1235	10296	
10	BARWA	1247	11543	
11	GYANPUR	252	11795	
12	BERUARBARI	3175	14970	3
13	DURGIPUR	2532	17502	
14	KARIHARA	495	17997	
15	DHANIDHARA	1215	19212	4
16	GANDHINAGAR	625	19837	
17	TARDILA	1125	20962	
18	KARAMMAR	7468	28430	5
19	KUMIYAHARA	1723	30153	6
20	SULTANPUR	1813	31966	
21	BAISAHAN	785	32751	
22	BANSPALI	485	33236	
23	MIDDHA	2235	35471	7
24	DATIWAR	3522	38993	
25	RAIPUR	381	39374	8
26	KHADAILA	1700	41074	
27	MAHUI	815	41889	
28	APAEL	3240	45129	9
29	PIRAKPUR	315	45444	
30	SHIVPUR	3952	49396	
31	BHAWARPUR	1235	50631	10
32	SAPAHI-1	414	51045	
33	SUKHPURA	15870	66915	11,12,13

34	BHARKHARA	3582	70497	14
35	JAINAGAR	1574	72071	
36	BHOJPUR MATHIA	2667	74738	15
37	HARPUR CHAPRA	2232	76970	
38	BILLARI	768	77738	
39	SARYAKHAP + BILLARI	165	77903	
40	KARAMPUR	1125	79028	
41	KESRIPUR	1128	80156	16
42	SHAHPUR	2840	82996	
43	KATARIA	362	83358	
44	HATIWATA	50	83408	
45	SHAHUDIH	4021	87429	17
46	JAYATIPAR	1506	88935	
47	AASCHAURA	4580	93515	18
48	NARAYANPUR	1036	94551	
49	BADSARI	2016	96567	19
50	JAMALPUR	356	96923	
51	TANDWA	1225	98148	
52	KALPURA	108	98256	
53	RAJPUR	5109	103365	20
54	SHIVRAMPUR	3984	107349	21
55	SUJOULI	423	107772	
56	MARITAR	10905	118677	22,23
57	SHINGHOLI	108	118785	
58	MISRAULIA	1885	120670	24
59	BIJLIPUR	35	120705	
60	SARHARIA	70	120775	
61	SHIVRAMPATTI	800	121575	
62	MAJUI /MAJHOS.	1135	122710	
63	ADAR	2230	124940	
64	DADAR	150	125090	
65	ABDULLAPUR	80	125170	
66	NARAINPUR .V. MANDIR	2535	127705	25
67	ASEGI	1215	128920	
68	SIMRI RAMPUR	2565	131485	26
69	DHANPALIA	735	132220	
70	PAHIYA	814	133034	
71	DHANPAR	565	133599	
72	JANPUR	350	133949	
73	PURENDARPUR	425	134374	
74	CHITRAULI	2033	136407	27
75	HARIJANPUR	725	137132	

76	ACCHUI	1545	138677	
77	DHANAUTI	3545	142222	28
78	GOPALPURKALA	855	143077	
79	SAPAHI-2	721	143798	
80	KAITHOLI	5254	149052	29
81	AKHTIYARPUR	85	149137	
82	BHOJPUR	2667	151804	30

151804

Cluster no. 14 shifted from Bharkara to Harpurchapra, as resistance was faced during last year's
survey in the former village.

Annex iv
Cluster Assignment & Logistics

September 2001

	TEAM # 1	**PERSON**	**DAY 1**	**DAY 2**
	Supervisor	Uttam Das	Jeep No.4	Jeep No.4
	1st Interviewer	Poonam Devi		
	2nd Interviewer	Girija Devi	Cluster: Middha (7)	Cluster: Shivrampur (21)
	Gate Keeper	Sarvajeet Kumar Raj kiahore Sahni		
	TEAM # 2	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor	Vinod Kumar	Jeep No 1.	Jeep No.1
	1st Interviewer	Usha Pandey		
	2nd Interviewer	Indrawti	Cluster: Babhnauli (2)	Cluster:Shahudih (17)
		Ishwar Chand Ramlal Yadav		

	Gate Keeper			
	TEAM # 3	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Srikant Yadav Maya Gupta Usha Singh Virender Verma Triloki Nath	Jeep No. 1 Cluster: Suryapura (1)	Jeep No.1 Cluster:Aschaura (18)
	TEAM # 4	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Sanjay Singh Hira Moti Meera Singh Raju Yadav Dinesh	Jeep No. 2 Cluster:Beruarbari (3)	Jeep No.2 Cluster:Badsari (19)
	TEAM #5	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Ganesh Yadav Usha Verma Urmila Singh Vijay Peter Kartik Prashant	Jeep No. 2 Cluster:Dhanidhara (4)	Jeep No.2 Cluster:Rajpur (20)

	TEAM # 6	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Manoj Kumar Vijay Shankar Meena Yadav Janki Devi Arvind Kumar Bihari Lal	Jeep No. 4 Cluster: Raipur/Dativer(8)	Jeep No.4 Cluster: Mishraulia (24)
	TEAM # 7	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Kamlesh Singh Reeta Singh Indumati Shivnath Pandey Naveen Sahu	Jeep No. 5 Cluster:Apayal (9)	Jeep No.7 Cluster: Simri Rampur (26)
	TEAM # 8	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer	Naveen Nischal Sunita Devi Rajkumari Uma Shankar	Jeep No. 8 Cluster:Harpur Chappra (14)	Jeep No.3 Cluster: Kesripur (16)

	Gate Keeper			

	TEAM #9	PERSON	CLUSTER 1	CLUSTER 2
	Supervisor	Shailender Vimal	Jeep No. 3	Jeep No.6
	1st Interviewer	Savita Ojha		
	2nd Interviewer	Shailkumari	Cluster: Kumihara (6)	Cluster:Maritar (22)
	Gate Keeper	Sunil Dennis		
	TEAM #10	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor	Chandmati	Jeep No. 3	Jeep No.6
	1st Interviewer	Chattiya Devi Premkumari		
	2nd Interviewer	Ramawti Verma	Cluster: Karammar (5)	Cluster:Maritar (23)
	Gate Keeper	Gupteshwar		
	TEAM # 11	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor	Sheila Singh	Jeep No. 5	Jeep No.7
	1st	Shobha Devi		

	Interviewer 2nd Interviewer Gate Keeper	Vimlesh Singh Sambunath Pandey	Cluster:Bhawarpur (10)	Cluster: Vidya Narayanpur (25)
	TEAM # 12	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Asha Devi Pratibha Tiwari Radhika Devi ArunKumar Uday Shankar	Jeep No. 6 Cluster:Sukhpura (12)	Jeep No.7 Cluster: Chitrauli (27)
	TEAM #13	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Girija Pathak Shobha Pandey Anita Singh Vinay Kumar Ram Kripal	Jeep No. 6 Cluster: Sukhpura (11)	Jeep No.8 Cluster: Kaithauli (29)
	TEAM # 14	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
		Anita Matthews	Jeep No.7	Jeep No.5

	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Seema Verma Vimla Devi Srinath Yadav Sujeet Kumar	Cluster: Sukhpura (13)	Cluster:Dhanauti (28)
	TEAM # 15	**PERSON**	**CLUSTER 1**	**CLUSTER 2**
	Supervisor 1st Interviewer 2nd Interviewer Gate Keeper	Anita Joshua Shanti Devi Tarkeshwari Jagat Narayan Ram Sanihi	Jeep No. 7 Cluster: Shahpur (15)	Jeep No.3 Cluster: Karampur (30)

ANNEX v
EPI INFO ANALYSIS TABLES

AGE &SEX

AGE WISE BREAKDOWN OF CHILDREN

Age in months	Freq	Percent	Cum.
0	39	6.5%	6.5%
1	27	4.5%	11.0%
2	35	5.8%	16.8%
3	25	4.2%	21.0%
4	24	4.0%	25.0%
5	21	3.5%	28.5%
6	20	3.3%	31.8%
7	25	4.2%	36.0%
8	33	5.5%	41.5%
9	29	4.8%	46.3%

10	16	2.7%	49.0%
11	6	1.0%	50.0%
12	47	7.8%	57.8%
13	33	5.5%	63.3%
14	33	5.5%	68.8%
15	27	4.5%	73.3%
16	25	4.2%	77.5%
17	19	3.2%	80.7%
18	19	3.2%	83.8%
19	25	4.2%	88.0%
20	17	2.8%	90.8%
21	16	2.7%	93.5%
22	26	4.3%	97.8%
23	13	2.2%	100.0%
Total	600	100.0%	

GENDER BREAKDOWN OF CHILDREN

Sex of Child	Freq	Percent	Cum.	95% Conf Limit
Boy	335	55.8%	55.8%	51.8%-59.8% *
Girl	265	44.2%	100.0%	40.2%-48.2% *
Total	600	100.0%		

CHILD BEARING AGE OF WOMEN

Mother's Age	Freq	Percent	Cum.
17	2	0.3%	0.3%
18	2	0.3%	0.7%
19	1	0.2%	0.8%
20	46	7.7%	8.5
21	17	2.8%	11.3%
22	47	7.8%	19.2%
23	28	4.7%	23.8%
24	48	8.0%	31.8%
25	116	19.3%	51.2%
26	32	5.3%	56.5%
27	15	2.5%	59.0%
28	58	9.7%	68.7%
29	6	1.0%	69.7%
30	112	18.7%	88.3%
31	2	0.3%	88.7%
32	25	4.2%	92.8%

33	3	0.5%	93.3%
34	6	1.0%	94.3%
35	25	4.2%	98.5%
36	3	0.5%	99.0%
37	1	0.2%	99.2%
40	4	0.7%	99.8%
45	1	0.2%	100.0%
Total	600	100.0%	

IMMUNIZATION

POSSESSION OF IMMUNIZATION CARD

Immunization Card	Freq	Percent	Cum.	95% Conf Limit
Yes	302	50.3%	50.3%	46.3%-54.4%
Lost it	214	35.7%	86.0%	31.9%-39.7%
Never had one	84	14.0%	100.0%	11.4%-17.1%
Total	600	100.0%		

% OF MOTHERS WHO HAD 2TT IN PERVIOUS PREGNANCY (CARD DOCUMENTED)

TT Injection	Freq	Percent	Cum.	95% Conf Limit
None	1	0.8%	0.8%	0.0%- 4.3%
One	16	12.5%	13.3%	7.3%-19.5%
Two	110	85.9%	99.2%	78.7%-91.4%
More than two	1	0.8%	100.0%	0.0%- 4.3%
Total	128	100.0%		

%MOTHERS WHO HAD 2TT DURING PREVIOUS PREGNANCY (BASED ON MOTHER'S RECALL)

TT injection	Freq	Percent	Cum.	95% Conf Limit
One	22	7.3%	7.3%	4.7%-10.9%
Two	213	71.0%	78.3%	65.5%-76.1%
More than two	39	13.0%	91.3%	9.4%-17.3%
None	26	8.7%	100.0%	5.7%-12.4%
Total	300	100.0%		

POSSESSION OF IMMUNIZATION CARD AMONG THOSE WHO COULD RECALL 2TT IMMUNIZATIONS

Current selection: pregtt = 2 and 3

Immunization Card	Freq	Percent	Cum.
Yes	110	51.6%	51.6%
Lost it	69	32.4%	84.0%
Never had one	34	16.0%	100.0%
Total	213	100.0%	

IMMUNIZATION OF CHILDREN AGED >=11MONTHS

Immunization

Card Documented

Vaccine	Num..	Den.	%
BCG	154	167	92.2
OPV1	149	167	89.2
OPV2	138	167	82.6
OPV3	129	167	77.2
DPT1	153	167	91.6
DPT2	145	167	86.8
DPT3	132	167	79.0
Drop-out rate DPT-1 -3			11.4
Measles	124	167	74.3
Fully Immunized	124	167	74.3

Mothers' Recall

Vaccine	Num..	Den.	%
BCG	159	300	53.0
OPV1	31	300	10.3
OPV2	22	300	7.3
OPV3	14	300	4.7
DPT1	99	300	33.0
DPT2	93	300	31.0
DPT3	86	300	28.7
Drop-out rate DPT-1 -3			13.1
Measles	97	300	32.3
Fully immunized	97	300	32.3

VITAMIN A DEFICIENCY/SUPPLEMENTATION

VITAMIN A COVERAGE IN PAST 6 MONTHS(BASED ON MOTHERS' RECALL)

VITAPAST6	Freq Percent Cum. 95% Conf Limit
Yes	160 53.3% 53.3% 47.5%-59.1%
No	140 46.7% 100.0% 40.9%-52.5%
Total	300 100.0%

% CHILDREN > 11 MONTHS AGE, WHO WERE GIVEN A CARD DOCUMENTED DOSE OF VITAMIN A IN PAST 6 MONTHS

Vitamin A 6 months	Freq Percent Cum.
Yes	125 74.9% 74.9%
No	42 25.1% 100.0%
Total	167 100.0%

%MOTHERS WHO REPORTED NIGHTBLINDNESS DURING PREVIOUS PREGANCY

Difficult to seeing	Freq Percent Cum.
Yes	47 15.7% 15.7%
No	250 83.6% 99.3%
Do not know	2 0.7% 100.0%
Total	299 100.0%

%MOTHERS REPORTING CURRENT NIGHT BLINDNESS

Night blindness	Freq Percent Cum.
Yes	62 10.3% 10.3%
No	538 89.7% 100.0%
Total	600 100.0%

<u>CARE DURING PREGNANCY</u>

% MOTHERS WHO HAVE RECALLED HAVING TAKEN 90 OR MORE IFA TABLETS DURING PREVIOUS PREGNANCY

Current selection: irontake >=90 and < 999

IRON Tab | Freq Percent Cum.

90	27	28.1%	28.1%
100	63	65.6%	93.8%
150	2	2.1%	95.8%
221	1	1.0%	96.9%
222	1	1.0%	97.9%
302	1	1.0%	99.0%
502	1	1.0%	100.0%
Total	96	100.0%	

total % = 32

UTILIZATION OF OBSTETRIC SERVICES

Help from	Freq	Percent	Cum.
Relatives	123	41.0%	41.0%
Untrained TBA	33	11.0%	52.0%
Trained TBA	22	7.3%	59.3%
Chamain	22	7.3%	66.7%
Govt. ANM	30	10.0%	76.7%
Private ANM	44	14.7%	91.3%
Unqualified (RMP) Practitioner	11	3.7%	95.0%
PHC/Distt Hospital	13	4.3%	99.3%
None	2	0.7%	100.0%
Total	300	100.0%	

<u>BREASTFEEDING/INFANT NUTRITION</u>

PRACTICE OF EXCLUSIVE BREAST FEEDING UP TO 6 MONTHS OF AGE

Current selection: cage <=6

Only breastfeeding	Freq	Percent	Cum.
No	27	14.1%	14.1%
Yes	164	85.9%	100.0%
Total	191	100.0%	

PRACTICE OF EXCLUSIVE BREAST FEEDING UP TO 4 MONTHS OF AGE

Current selection: cage <=4

Only Breastfeeding	Freq Percent Cum.
No	11 7.3% 7.3%
Yes	139 92.7% 100.0%
Total	150 100.0%

COMMONLY USED WEANING FOODS

MILK	Freq Percent Cum.
No	331 55.2% 55.2%
Yes	269 44.8% 100.0%
Total	600 100.0%

DAL	Freq Percent Cum.
No	228 38.0% 38.0%
Yes	372 62.0% 100.0%
Total	600 100.0%

RICE	Freq Percent Cum.
No	247 41.2% 41.2%
Yes	353 58.8% 100.0%
Total	600 100.0%

ROTI	Freq Percent Cum.
No	413 68.8% 68.8%
Yes	187 31.2% 100.0%
Total	600 100.0%

VEGETABLE	Freq Percent Cum.
No	349 58.2% 58.2%
Yes	251 41.8% 100.0%
Total	600 100.0%

FRUITS	Freq Percent Cum.

No	513	85.5%	85.5%
Yes	87	14.5%	100.0%
Total	600	100.0%	

EGGS & MEAT	Freq	Percent	Cum.
No	292	97.3%	97.3%
Yes	8	2.7%	100.0%
Total	300	100.0%	

Only breast milk	Freq	Percent	Cum.
No	403	67.2%	67.2%
Yes	197	32.8%	100.0%
Total	600	100.0%	

AGE AT WEANING

Weaning Age	Freq	Percent	Cum.
1	6	1.1%	1.1%
2	94	17.0%	18.1%
3	2	0.4%	18.4%
4	8	1.4%	19.9%
5	9	1.6%	21.5%
6	150	27.1%	48.6%
7	40	7.2%	55.9%
8	58	10.5%	66.4%
9	19	3.4%	69.8%
10	36	6.5%	76.3%
11	5	0.9%	77.2%
12	44	8.0%	85.2%
13	3	0.5%	85.7%
14	2	0.4%	86.1%
15	6	1.1%	87.2%
17	4	0.7%	87.9%
18	3	0.5%	88.4%
Do not remember	64	11.6%	100.0%
Total	553	100.0%	

ESSENTIAL CARE OF THE SICK CHILD

% MOTHERS WHO KNEW SIGNS OF ILLNESS IN CHILDREN THAT SHOULD PROMPT IMMEDIATE TREATMENT.

FEVER	Freq	Percent	Cum.
No	101	16.8%	16.8%
Yes	499	83.2%	100.0%
Total	600	100.0%	

COUGH	Freq	Percent	Cum.
No	260	43.3%	43.3%
Yes	340	56.7%	100.0%
Total	600	100.0%	

Fast breathing	Freq	Percent	Cum.
No	317	52.8%	52.8%
Yes	283	47.2%	100.0%
Total	600		

DIFFBREATH	Freq	Percent	Cum.
No	379	63.2%	63.2%
Yes	221	36.8%	100.0%
Total	600	100.0%	

LOOSESTOOL	Freq	Percent	Cum.
No	338	56.3%	56.3%
Yes	262	43.7%	100.0%
Total	600	100.0%	

BLOOD STOOL	Freq	Percent	Cum.
No	474	79.0%	79.0%
Yes	126	21.0%	100.0%
Total	600	100.0%	

UNCONSCIOUS	Freq	Percent	Cum.
No	494	82.3%	82.3%
Yes	106	17.7%	100.0%
Total	600	100.0%	

VOMITING	Freq	Percent	Cum.
No	441	73.5%	73.5%
Yes	159	26.5%	100.0%
Total	600	100.0%	

UNABLE to eat & drink	Freq	Percent	Cum.
No	536	89.3%	89.3%
Yes	64	10.7%	100.0%
Total	600	100.0%	

% MOTHERS WHO WOULD TAKE THEIR CHILD FOR TREATMENT AND TO WHOM

Treatment by	Freq	Percent	Cum.
Local RMP doctor	425	71.0%	71.0%
Govt. ANM	25	4.2%	75.1%
PHC treatment	3	0.5%	75.6%
Private ANM	52	8.7%	84.3%
Private hospital Ballia	22	3.7%	88.0%
District hospital Ballia	72	12.0%	100.0%
Total	599	100.0%	

<u>BIRTH SPACING/FAMILY PLANNING</u>

%MOTHERS WHO ARE PREGNANT NOW

Pregnant now	Freq	Percent	Cum.	95% Conf Limit
Yes	60	10.0%	10.0%	7.8%-12.8% *
No	533	88.8%	98.8%	86.0%-91.2% *
Do not know	7	1.2%	100.0%	0.5%- 2.5% *

Total | 600 100.0%

% MOTHERS WHO DO NOT WANT ANOTHER CHILD IN THE NEXT 2 YEARS, OR WHO ARE NOT SURE, WHO ARE USING A MODERN CONTRACEPTIVE METHOD.

Current selection: WANTCHILD = 2

MOTHERS WITH CHILDREN AGED 12 - 23 MONTHS

Prevent pregnancy | Freq Percent Cum. 95% Conf Limit

Yes | 46 24.2% 24.2% 18.3%-30.9%
No | 144 75.8% 100.0% 69.1%-81.7%

Total | 190 100.0%

MOTHERS WITH CHILDREN AGED 0 -11 MONTHS

USING Method | Freq Percent Cum. 95% Conf Limit

Yes | 61 27.4% 27.4% 21.6%-33.7%
No | 162 72.6% 100.0% 66.3%-78.4%

Total | 223 100.0%

Mean % = 97/413 = 23.4%

CONTRACEPTIVE USE BY TYPE

CONDOM | Freq Percent Cum.

No | 47 43.5% 43.0%
Yes | 61 46.5% 100.0%

Total | 108 100.0%

Oral pills | Freq Percent Cum.

No | 89 82.4% 82.4%
Yes | 19 17.6% 100.0%

Total | 108 100.0%

Copper T | Freq Percent Cum.

No	107	99.1%	99.1%
Yes	1	0.9	100.0%
Total	108	100.0%	

Male sterilization	Freq	Percent	Cum.
No	107	99.9%	99.9%
Yes	1	0.9%	100.0%
Total	108	100.0%	

Female Sterilization	Freq	Percent	Cum.
No	85	78.7%	78.5%
Yes	23	21.3%	100.0%
Total	108	100.0%	

ANNEX vi

THE QUESTIONNAIRES

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT
Beruarbari Block, BALLIA
(Questionnaire for Mothers with Children 0 - 11 MOTHERS)
Knowledge and Practice (KPC) - 2001 Survey

Date of data {entry} or most recent revision of record <today/yyyy>

ID{NUMBERS} <A____>

{CLUSTER} Name:_____
Date of Interview {Dateint}: <dd/mm/yyyy>
{Name} of {Inter}viewer: _____

IDENTIFICATION
Age of Mother {MAge}: ## in years

Child who is less than 0 to 11 months old: {Boy}or{Girl}: #
USE CODE 1=BOY, 2=GIRL

Date of birth {Bdate}: <dd/mm/yyyy> Age of child {CAge}: ## in months

1. When you were {preg}nant, how many{TT} injections did you get ? #

1) One
2) Two
3) More then two
4) Do not remember
5) None

2. Do you have your {imm}ization {card} with you ? #
   1) Yes
   2) Lost it -(Go to 4)
   3) Never had one - (Go to 4)

3. See the card and note here the details of TT immunization.
   1) {TT1 Date} <dd/mm/yy>
   2) {TT2 Date} <dd/mm/yy>
   A) {How} {many} {TT} immunizations have been received- #

4. While you were pregnant, how many {Iron} tablets did you {take} ? ###

None = 0
Do not remember = 999

5. When you were pregnant, did you have {diff}iculty {see}ing in the dark? #
1= Yes
2= No
3= Do not remember

6. Who {help}ed you in {del}ivery of (----------) ? #
1) Relative
2) Untrained TBA
3) Trained TBA
4) Chamain
5) Govt. ANM
6) Private ANM
7) Unqualified (RMP) practitioner
8) PHC /Dist Hospital/priv Hosp
9) None

7. Are you breast{feed}ing (----------) {now} ? #
1= Yes
2= No

8.a. What other foods/ fluids did you give (----------) since yesterday ?
1) {Tea}.....<A>
2) {Water}.....<A>
3) Animal {milk}.....<A>
4) {Dal}.....<A>
5) {Rice}.....<A>
6) {Roti}.....<A>
7) {Vegetable}.....<A>
8) {Fruits}.....<A>
9) {Eggs Meat} /Fish.....<A>
10) {Other food}_____
11) {None} (only breast milk)...<A>

b. At {what age} did you start giving (----------) these foods? ##
Do not remember = 99

9. Sometimes children get sick and need to be taken for treatment. What signs of illness in a child should prompt you to seek treatment ?

1) {Fever}.....<A>
2) {Cough}.....<A>
3) {Fast breath}ing.....<A>
4) {Diff}icult {breath}ing.....<A>
5) {Loose stools}.....<A>
6) {Blood} in {stool}s <A>
7) {Unconsc}iousness.....<A>
8) {Vomiting} everything.....<A>
9) {Unable} to {eat} or drink....<A>
10) {Other signs}_____
11) Do {not know}.....<A>

10. Where would you {take} a Child for {treat}ment ? #

1) Local RMP doctor
2) Govt. ANM
3) PHC treatment
4) Private ANM
5) Private hospital in Ballia
6) District hospital in Ballia

11. Are you {preg}nant {now}? #
1= Yes (Go to Q.17)
2= No
3= Do not Know.

12. After the birth of (----------) did you become {preg}nant {again}? #
1= Yes
2= No - Go to 14
3= Do not know - Go to 14

13. Then {what} did you {do}? #
1= Abort it
2= There was a spontaneous abortion
3= Do not know

14. Do you {want} another {child} in the next two years ? #
1= Yes (Go to Q.17)
2= No
3= Do not Know

15. Are you or your husband {using} any method to prevent pregnancy ? #
1) Yes
2) No - (Go to Q.17)

16. What method are you using ?
   1) {Condoms}.....<A>
   2) {Oral Pills}.....<A>
   3) {Copper T}.....<A>
   4) {Male} {steril}ization.....<A>
   5) {Female} {steril}ization.....<A>
   6) {Other}_____

17. Do you have {night blind}ness now ? #
   1 = Yes
   2 = No

-------END OF THE QUESTIONNAIRE------
-----WELL DONE !!------

BALLIA RURAL INTEGRATED CHILD SURVIVAL PROJECT
Beruarbari Block, BALLIA
Knowledge and Practice (KPC) - 2001 Survey
(Questionnaire for Mothers with Children 12 - 23 MONTHS)

Date of data {entry} or most recent revision of record <today/yyyy>

ID{NUMBERS} <A____>

{CLUSTER} Name:_____
Date of Interview {Dateint}: <dd/mm/yyyy>
{Name} of {Inter}viewer: _____

IDENTIFICATION
Age of Mother {MAge}: ## in years

Child who is between 12 - 23 months old: {Boy}or{Girl}: #
USE CODE 1=BOY, 2=GIRL

Date of birth {Bdate}: <dd/mm/yyyy> Age of child {CAge}: ## in months

a). Are you breast {feed}ing (----------) {now} #
   1= Yes
   2= No

b).1. What other foods/fluids did you give (----------) since yesterday ?

1) {Tea}.....<A>
2) {Water}.....<A>
3) Animal {Milk}.....<A>
4) {Dal}.....<A>
5) {Rice}.....<A>
6) {Roti}.....<A>
7) {Vegetable}.....<A>
8) {Fruits}.....<A>
9) {Egg Meat} /Fish.....<A>
10) {None} (Only breastmilk).....<A>

2. At {what age} did you start giving (----------) these foods? ##
Do not remember = 99

3. Can you recollect and tell me all the immunizations (----------) has got ?
(prompt : any other--) (Blank entry 99)

Immunization	At what age (in months)
a) {Imm1}_____	{Age1}: ##.# {RECALL1} <A>
b) {Imm2}_____	{Age2}: ##.# {RECALL2} <A>
c) {Imm3}_____	{Age3}: ##.# {RECALL3} <A>
d) {Imm4}_____	{Age4}: ##.# {RECALL4} <A>
e) {Imm5}_____	{Age5}: ##.# {RECALL5} <A>
f) {Imm6}_____	{Age6}: ##.# {RECALL6} <A>
g) {Imm7}_____	{Age7}: ##.# {RECALL7} <A>

4). Did (----------) get a dose of {Vit A} in the {past 6} months ?#
1= Yes
2= No
3= Do not remember

5). Do you have an {imm}ization {card} for (----------) ? #
1= Yes
2= Lost it (Go to Q.7)
3= Never had one (Go to Q.7)

6).a) See the card and note the immunizations details here.

1) {BCG}.....<dd/mm/yy>
2) {DPT1}.....<dd/mm/yy>
3) {OPV1}.....<dd/mm/yy>
4) {DPT2}.....<dd/mm/yy>
5) {OPV2}.....<dd/mm/yy>

6) {DPT3}.....<dd/mm/yy>
7) {OPV3}.....<dd/mm/yy>
8) {Measles}.....<dd/mm/yy>

b) {Full Imm}ization.....# 1 = Yes, 2 = No

c). Has child received a dose of {Vit A} in the past {6} months? #

1 = Yes if Yes {Vit A1 date}: <dd/mm/yy>
2 = No {Vit A2 date}: <dd/mm/yy>
{Vit A3 date}: <dd/mm/yy>

7). Sometimes children get sick and need to be taken for treatment.
What signs of illness should prompt you to take a Child for treatment ?

1) {Fever}.....<A>
2) {Cough}.....<A>
3) {Fast} {breath}ing.....<A>
4) {Diff}icult {breath}ing.....<A>
5) {Loose stool}s.....<A>
6) {Blood} in {stool}s.....<A>
7) {Unconsc}iousness.....<A>
8) {Vomiting} everything.....<A>
9) {Unable} to {eat} or drink...<A>
10) {Other sings}_____
11) {Do not Know}.....<A>

8). Where would you {take} the child for {treat}ment ? #

1 = Local RMP
2 = Govt ANM
3 = PHC
4 = Private ANM
5 = Private hospital in Ballia
6 = District hospital in Ballia

9). Are you {preg}nant {now} ? #

1 = Yes (Go to Q.15)
2 = No
3 = do not know

10). After the birth of (----------) did you become {preg}nant {again}? #
1 = Yes

2 = No (Go to Q.12)
3 = Do not know (Go to Q.12)

11). Then {what} did you {do} ? #
1 = Aborted it.
2 = There was a spontaneous abortion.

12) Do you {want} another {child} in the next 2 years ? #
1= Yes (Go to Q.15)
2= No
3= Do not know

13) Are you or your husband using any method to {prevent} {preg}nancy? #
1 = Yes
2 = No (Go to Q.15)

14) What method are you using ?
1) {Condom}.....<A>
2) {Oral Pills}.....<A>
3) {Copper T}.....<A>
4) {Male steril}ization.....<A>
5) {Female steril}ization...<A>
6) {Oth}er {method}.....<A>

15) Do you have {night blind}ness now ? #

1 = Yes
2 = No

-----END OF THE QESTIONNIARE------
-----WELL DONE !!----